

Patient Authorization and Notice of Release of Information



Dear Patient:

XOLAIR® Access Solutions™ is a program sponsored by Genentech through one or more of its affiliates (“Genentech”) that provides support services such as benefits investigations, prior authorizations and appeals assistance at no charge to patients and assists them in obtaining reimbursement for XOLAIR® (Omalizumab) For Subcutaneous Use. If a patient does not have insurance or is deemed uninsured due to denial by private and public payers, and the patient meets certain financial and medical criteria, the patient may be eligible to receive XOLAIR free of charge from the Genentech® Access to Care Foundation. Additional information about these programs can be found at XOLAIRAccessSolutions.com. In order for XOLAIR Access Solutions and Genentech Access to Care Foundation to provide the described services, we will need to review, use and disclose your protected health information (PHI). By law, only with your prior written authorization may your health care provider, health plan or health insurer disclose your PHI to XOLAIR Access Solutions and Genentech Access to Care Foundation. As soon as we obtain your prior written authorization, we will work to provide you with the services.

You are not required to agree to this Authorization. However, if you choose not to provide this Authorization neither XOLAIR Access Solutions nor the Genentech Access to Care Foundation will be able to provide you and/or your doctor with assistance. You will receive a copy of the Authorization you sign. Please review this Authorization carefully. If you have any questions regarding this Authorization, please contact your health care provider’s office. Contact information is included below.

AUTHORIZATION

I. Information to Be Disclosed or Used

This Authorization permits my health care providers, health plans and health insurers who provide services to me to use and disclose to XOLAIR Access Solutions or Genentech Access to Care Foundation, and its authorized agents and assignees, all medical records and financial information with respect to my treatment, which may have bearing on the benefits payable for services or products provided through my health care provider, health plan or insurer under any plan providing benefits or services, including, without limitation, the dollar balance of benefits remaining under any applicable lifetime maximum benefits provisions, or which may have a bearing on my medical condition or compliance with therapy. All of this information may be considered PHI, and may, if relevant, include information about HIV/AIDS and/or other communicable diseases, mental health information, and/or information concerning genetic test results.

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II. Persons Authorized to Disclose Information

The PHI identified in Paragraph I may be disclosed by my health care provider, health plan, health insurer or others who may hold my PHI.

III. Persons to Whom Disclosure May Be Made

The PHI identified in Paragraph I may be disclosed to and/or used by XOLAIR Access Solutions, Genentech Access to Care Foundation or Clinical Sales Representatives, their sponsor, Genentech, a biopharmaceutical manufacturer located at 1 DNA Way, Mail Stop #210, South San Francisco, CA 94080, and its related entities, their agents or assignees and certain Genentech business partners such as Novartis Pharmaceuticals Corporation, as well as other companies involved in the administration of certain Genentech products.

IV. Description of Each Purpose

My PHI may be used for the purposes of reimbursement and/or participation in a coverage and reimbursement assistance or patient assistance program administered by XOLAIR Access Solutions and Genentech Access to Care Foundation, respectively. My PHI also may be used for purposes of tracking the general use of a Genentech product, assessing and improving Genentech's coverage and reimbursement and patient assistance services, and proper management and administration of Genentech's business. In addition, should I elect to participate in the Xpansions program, a free patient support program sponsored by Genentech, Inc. and Novartis Pharmaceuticals Corporation, my PHI may be shared with the Xpansions program.

V. Expiration Date or Event

California residents only: This Authorization will be effective, unless revoked by me in writing, until December 31, 2015.

All other residents: This Authorization will be effective, unless revoked by me in writing, up to one year from the date of this Authorization.

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VI. Notices

I understand that once my PHI is disclosed pursuant to this Authorization, there is no guarantee under federal law that the recipient will not redisclose my PHI to a third party. Any such third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my PHI. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my health care provider's treatment of me. If I refuse to sign or revoke this Authorization, however, it may affect the continuation of any services that may have otherwise been provided by XOLAIR Access Solutions or Genentech Access to Care Foundation.

I understand that this Authorization will remain in effect until it expires as described or I provide a written notice of revocation via mail to XOLAIR Access Solutions, 1 DNA Way, Mail Stop #210, South San Francisco, CA 94080 or via fax to (800) 704-6612. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider or others referenced in this Authorization, including without limitation XOLAIR Access Solutions or Genentech Access to Care Foundation, in reliance on this Authorization before my health care provider received my written notice of revocation.

VII. Distribution Acknowledgment

I hereby state (or my parent/guardian hereby states) that if I should receive free product from Genentech Access to Care Foundation, I will utilize XOLAIR for the reason that my physician has prescribed it to me. I will not sell or distribute XOLAIR, as I acknowledge it is unlawful to do so. I will be responsible to ensure that XOLAIR will be delivered to a secure address for purposes of receipt of shipment, and I understand it is my duty to control XOLAIR while it remains in my possession.

VIII. Signature

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my PHI. By my signature below, I hereby knowingly and voluntarily authorize the use and/or disclosure of my PHI in the manner described.

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Access Solutions™
Treatment made possible.™

XOLAIRAccessSolutions.com

Signature Required

Patient Authorization Notice

Print Patient's Name

Signature of Patient or Guardian*

Description of Authority

Date

**If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally).*

Patient's/Guardian's Address

IX. FINANCIAL INFORMATION

Only uninsured patients (and patients whose insurance has denied treatment) who wish to apply to Genentech Access to Care Foundation for assistance need to fill out this section.

Complete If Necessary

Household Adjusted Gross Income:

\$0-25K/yr \$25,001-50K/yr \$50,001-75K/yr \$75,001-100K/yr

I understand that in order to qualify, my adjusted gross income may not exceed \$100K/yr. I certify that the above statement of my previous year's income is true and that I have no medical insurance coverage for XOLAIR, including Medicare, Medicaid or other public programs, and that I have insufficient financial resources to pay for the prescribed therapy. I also agree to furnish my IRS 1040 (or if none, then my Social Security Benefit Statement or W-2) within 45 days of the submission of this form. I understand that failure to provide this documentation may result in an interruption in therapy.

Signature of Patient
(complete if necessary)

Date Signed
(complete if necessary)

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Xpansions/Free Patient Support Plan

I authorize Genentech, Inc. and Novartis Pharmaceuticals Corporation (“Sponsors”) to enroll me in Xpansions, a patient support program. I understand that my personally identifiable information related to allergic asthma and my treatment with XOLAIR are required for participation in the support program. In addition to the information that I provide directly to the program, I understand that any personal information that I have provided will be shared between XOLAIR Access Solutions and the Xpansions program.

Xpansions is a community exclusively for people who have added XOLAIR to their allergic asthma treatment regimen.

By joining the Xpansions program, I understand that my personal information will be used by health professionals to support me while I am on XOLAIR. My personal information will also be used to track the general use of XOLAIR, to improve the support program, to provide me with relevant program materials and to help the Sponsors manage their businesses.

My information may be combined with additional information from this or other programs in which I participate, such as prescription information when I redeem savings cards or vouchers.

I understand that my personally identifiable information will be shared with the Sponsors, and/or their agents and affiliates, and my healthcare provider. I agree that I may be contacted in the future by mail, e-mail and/or telephone concerning the Xpansions program. The privacy and security of my personal information is important to Novartis and Genentech, Inc. The personal information I supply to you will be shared with and among your business partners, affiliates and agents to provide you with information, products, programs and services, and to conduct market research.

I understand that I do not have to sign this Authorization in order to receive XOLAIR or to be eligible for assistance from the XOLAIR Access Solutions or the Genentech patient assistance program and that I may cancel this Authorization at any time by calling 1-866-4XOLAIR (1-866-496-5247).

Xpansions

X

Signature of Patient*

Patient's E-mail Address

Patient's Phone

*You must sign above to enroll in the Xpansions program.

Date

Optional