ENROLLING PATIENTS

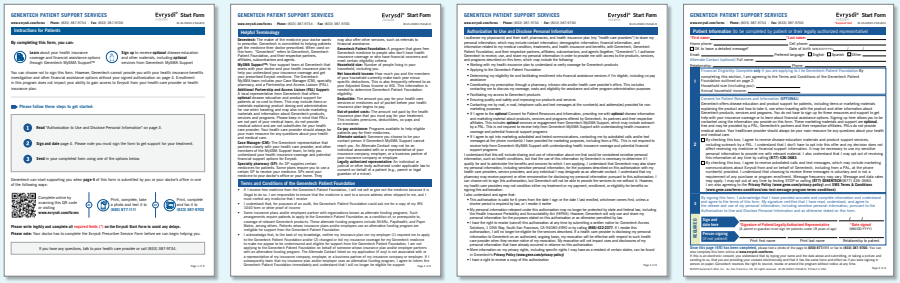
in MySMA Support™ by Genentech

MySMA Support is a support service from Genentech that can help provide information about Evrysdi® (risdiplam).

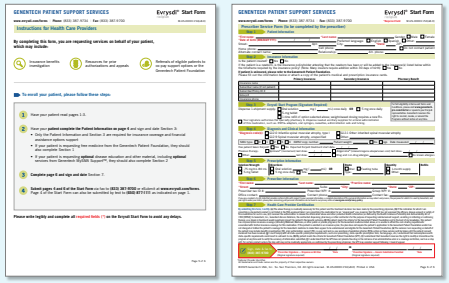
- The MySMA Support team can help you understand your patient's insurance coverage and refer your patients to appropriate financial assistance options to help them start and stay on Evrysdi
- MySMA Support does not provide medical advice and is not a substitute for the medical team. Health care providers should always be the main resource for any questions about patients' health and medical care

To enroll in MySMA Support, patients and providers simply need to complete the Evrysdi Start Form. Look inside for tips on completing the form.

Instructions, Consent Information and Patient Consent Form
Pages 1-4



Instructions and Prescriber Service Form
Pages 5-6



To learn more:

Visit Evrysdi-HCP.com

Call MySMA Support at (833) 387-9734
Monday through Friday, 9 a.m.–8 p.m. ET

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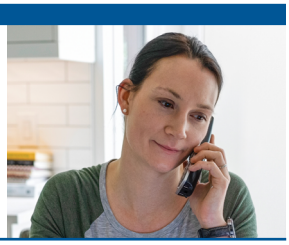
MySMA SUPPORT™ BY GENENTECH

FOR HEALTH CARE PROVIDERS

Tips for Completing the Evrysdi Start Form: **Patient/Caregiver Considerations**



Page 4 of the Evrysdi Start Form (the blue colored "Patient Consent Form") should be filled out by the patient or caregiver.

- **Be sure to carefully review Pages 1-3 of the Evrysdi Start Form with the patient or caregiver** before he or she completes **Page 4** to ensure complete understanding of the MySMA Support™ offerings
- Areas highlighted in **red** indicate required information. Please note that complete contact information, including an active email address, can expedite the approval process and help ensure patients quickly receive the full range of support and resources
- **This form also can be filled out online at Evrysdi.com/Forms**

Patient Information

Providing patient contact information and an alternate contact, including an active email address, can help us work with the patient most effectively.

Section 1

Needed to determine if the patient may be eligible for free Evrysdi® (risdiplam) from the Genentech Patient Foundation. The household size and income is used ONLY to determine eligibility.

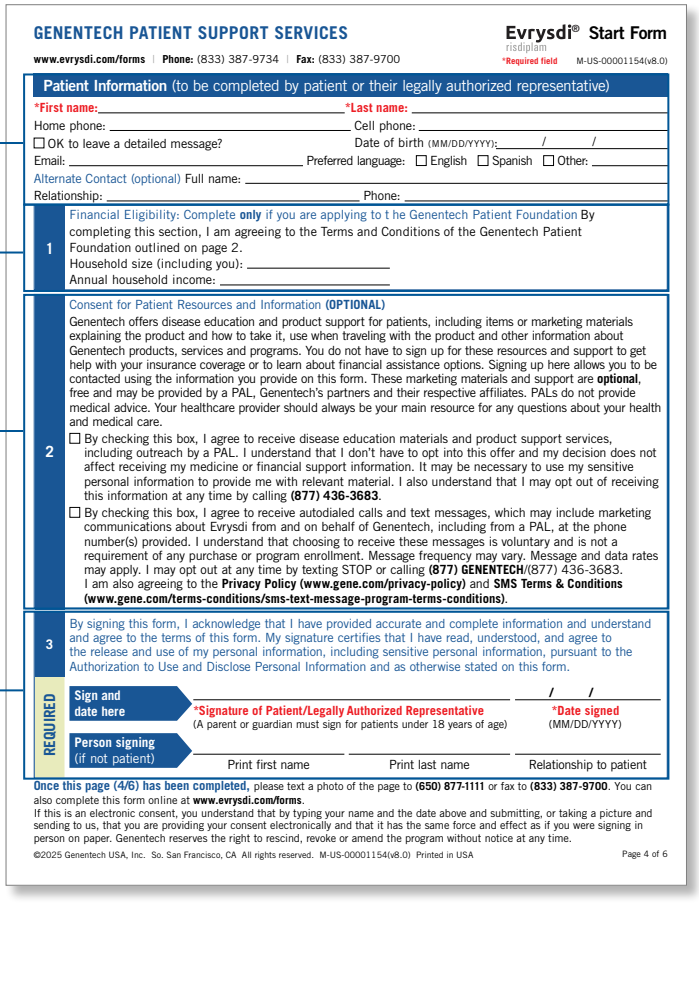
Note: Prescribers must complete the Prescriber Foundation Form (available at GenentechPatientFoundation.com) to complete enrollment.

Section 2

Complete this section if the patient would like to receive disease education materials and product support, including items or marketing materials explaining the product and how to take it, use when traveling and other information about Genentech products, services and programs

Section 3

Signature and date required for the patient to receive assistance from MySMA Support and the Genentech Patient Foundation.



GENENTECH PATIENT SUPPORT SERVICES

Evrysdi® risdiplam Start Form

www.evrysdi.com/forms | Phone: (833) 387-9734 | Fax: (833) 387-9700

*Required field M-US-00001154(v8.0)

Patient Information (to be completed by patient or their legally authorized representative)

*First name: _____ *Last name: _____

Home phone: _____ Cell phone: _____

☐ OK to leave a detailed message? Date of birth (MM/DD/YYYY): ___/___/___

Email: _____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Alternate Contact (optional) Full name: _____

Relationship: _____ Phone: _____

1 Financial Eligibility: Complete **only** if you are applying to t he Genentech Patient Foundation By completing this section, I am agreeing to the Terms and Conditions of the Genentech Patient Foundation outlined on page 2.

Household size (including you): _____

Annual household income: _____

2 Consent for Patient Resources and Information **(OPTIONAL)**

Genentech offers disease education and product support for patients, including items or marketing materials explaining the product and how to take it, use when traveling with the product and other information about Genentech products, services and programs. You do not have to sign up for these resources and support to get help with your insurance coverage or to learn about financial assistance options. Signing up here allows you to be contacted using the information you provide on this form. These marketing materials and support are **optional**, free and may be provided by a PAL, Genentech's partners and their respective affiliates. PALs do not provide medical advice. Your healthcare provider should always be your main resource for any questions about your health and medical care.

☐ By checking this box, I agree to receive disease education materials and product support services, including outreach by a PAL. I understand that I don't have to opt into this offer and my decision does not affect receiving my medicine or financial support information. It may be necessary to use my sensitive personal information to provide me with relevant material. I also understand that I may opt out of receiving this information at any time by calling **(877) 436-3683**.

☐ By checking this box, I agree to receive autodialed calls and text messages, which may include marketing communications about Evrysdi from and on behalf of Genentech, including from a PAL, at the phone number(s) provided. I understand that choosing to receive these messages is voluntary and is not a requirement of any purchase or program enrollment. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or calling **(877) GENENTECH**/(877) 436-3683. I am also agreeing to the **Privacy Policy (www.gene.com/privacy-policy)** and **SMS Terms & Conditions (www.gene.com/terms-conditions/sms-text-message-program-terms-conditions)**.

3 By signing this form, I acknowledge that I have provided accurate and complete information and understand and agree to the terms of this form. My signature certifies that I have read, understood, and agree to the release and use of my personal information, including sensitive personal information, pursuant to the Authorization to Use and Disclose Personal Information and as otherwise stated on this form.

REQUIRED

Sign and date here _____ *Signature of Patient/Legally Authorized Representative (A parent or guardian must sign for patients under 18 years of age) ___/___/___ *Date signed (MM/DD/YYYY)

Person signing (if not patient) _____ Print first name _____ Print last name _____ Relationship to patient

Once this page (4/6) has been completed, please text a photo of the page to **(650) 877-1111** or fax to **(833) 387-9700**. You can also complete this form online at **www.evrysdi.com/forms**.

If this is an electronic consent, you understand that by typing your name and the date above and submitting, or taking a picture and sending to us, that you are providing your consent electronically and that it has the same force and effect as if you were signing in person on paper. Genentech reserves the right to rescind, revoke or amend the program without notice at any time.

Page 4 of 6

Note: Patients must provide both a signature and date in Section 3.

Submit Page 4 by:

Completing it online using the QR code or visiting Evrysdi.com/Forms OR **Texting** a photo of the completed form to **(650) 877-1111** OR **Faxing** to **(833) 387-9700**

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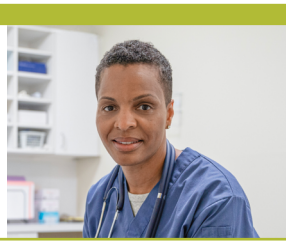
MySMA SUPPORT BY GENENTECH

Tips for Completing the Evrysdi Start Form: **Health Care Provider Considerations**



Page 6 of the Evrysdi Start Form (the green colored "Prescriber Service Form") should be filled out by the provider for all patient support requests.

- Areas highlighted in **red** indicate required information. Please note that completing the entire form can expedite the approval process and help ensure patients quickly receive the full range of support and resources
- **This form also can be filled out online at Evrysdi.com/Forms**

Step 2: Insurance Information

You may complete the insurance information in Step 2 or attach a copy of the patient's medical and prescription insurance cards.

Step 3: Evrysdi Starter Program

With the Evrysdi Starter Program, eligible patients may receive free medicine while awaiting an insurance coverage determination. Be sure to complete Step 3 and fill out the dispensing information to enroll your patient.

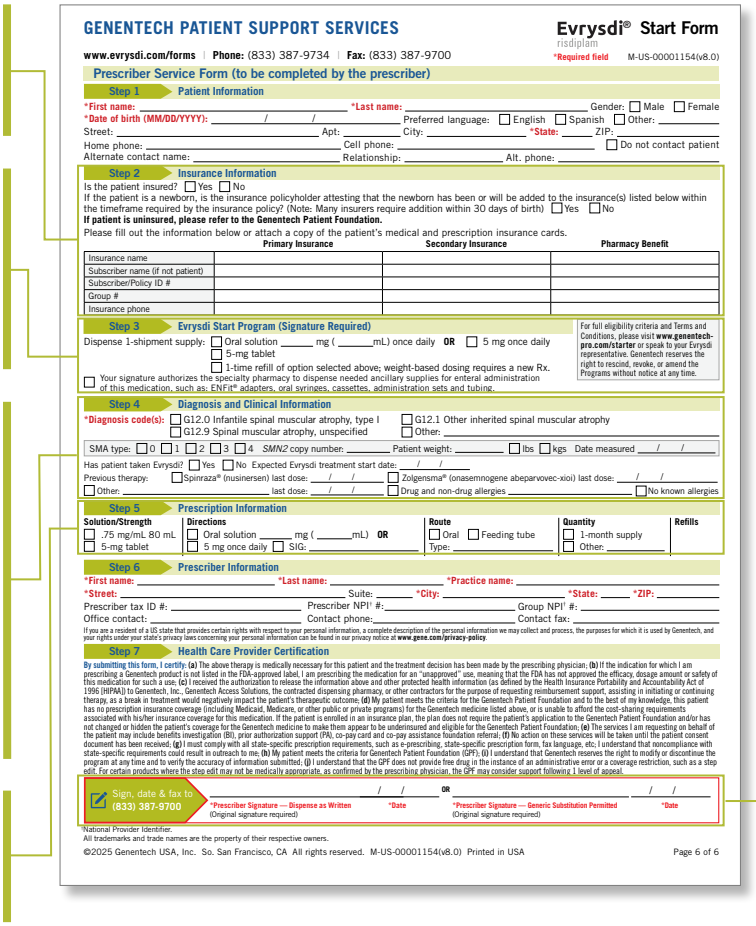
Step 4: Diagnosis and Clinical Information

To expedite processing and delivery, be sure to complete Step 4 in its entirety:

- Include the appropriate diagnosis code and copy number or type
- Please remember to select lb or kg for the patient's weight
- If the patient has been on a previous therapy, please select the therapy and include the date of the last dose

Step 5: Prescription Information

When completing this section, be sure to specify whether the patient will be taking the tablet or oral solution of Evrysdi.



GENENTECH PATIENT SUPPORT SERVICES

Evrysdi® Start Form
risdiplam

www.evrysdi.com/forms | Phone: (833) 387-9734 | Fax: (833) 387-9700

*Required field M-US-00001154(v8.0)

Prescriber Service Form (to be completed by the prescriber)

Step 1 Patient Information

*First name: _____ *Last name: _____ Gender: ☐ Male ☐ Female

*Date of birth (MM/DD/YYYY): ___/___/___ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Street: _____ Apt: _____ City: _____ *State: ____ ZIP: _____

Home phone: _____ Cell phone: _____ ☐ Do not contact patient

Alternate contact name: _____ Relationship: _____ Alt. phone: _____

Step 2 Insurance Information

Is the patient insured? ☐ Yes ☐ No

If the patient is a newborn, is the insurance policyholder attesting that the newborn has been or will be added to the insurance(s) listed below within the timeframe required by the insurance policy? (Note: Many insurers require addition within 30 days of birth) ☐ Yes ☐ No

If patient is uninsured, please refer to the Genentech Patient Foundation.

Please fill out the information below or attach a copy of the patient's medical and prescription insurance cards.

	Primary Insurance	Secondary Insurance	Pharmacy Benefit
Insurance name			
Subscriber name (if not patient)			
Subscriber/Policy ID #			
Group #			
Insurance phone			

Step 3 Evrysdi Start Program (Signature Required)

Dispense 1-shipment supply: ☐ Oral solution _____ mg (_____mL) once daily OR ☐ 5 mg once daily ☐ 5-mg tablet ☐ 1-time refill of option selected above; weight-based dosing requires a new Rx.

☐ Your signature authorizes the specialty pharmacy to dispense needed ancillary supplies for enteral administration of this medication, such as: ENFit® adapters, oral syringes, cassettes, administration sets and tubing.

For full eligibility criteria and Terms and Conditions, please visit www.genentech-pro.com/starter or speak to your Evrysdi representative. Genentech reserves the right to rescind, revoke, or amend the Programs without notice at any time.

Step 4 Diagnosis and Clinical Information

*Diagnosis code(s): ☐ G12.0 Infantile spinal muscular atrophy, type I ☐ G12.1 Other inherited spinal muscular atrophy ☐ G12.9 Spinal muscular atrophy, unspecified ☐ Other: _____

SMA type: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 *SMN2* copy number: _____ Patient weight: _____ ☐ lbs ☐ kgs Date measured ___/___/___

Has patient taken Evrysdi? ☐ Yes ☐ No Expected Evrysdi treatment start date: ___/___/___

Previous therapy: ☐ Spinraza® (nusinersen) last dose: ___/___/___ ☐ Zolgensma® (onasemnogene abeparvovec-xioi) last dose: ___/___/___

☐ Other: _____ last dose: ___/___/___ ☐ Drug and non-drug allergies _____ ☐ No known allergies

Step 5 Prescription Information

Solution/Strength	Directions	Route	Quantity	Refills
☐ .75 mg/mL 80 mL ☐ 5-mg tablet	☐ Oral solution _____ mg (_____mL) OR ☐ 5 mg once daily ☐ SIG: _____	☐ Oral ☐ Feeding tube Type: _____	☐ 1-month supply ☐ Other: _____	

Step 6 Prescriber Information

*First name: _____ *Last name: _____ *Practice name: _____

*Street: _____ Suite: _____ *City: _____ *State: ____ *ZIP: _____

Prescriber tax ID #: _____ Prescriber NPI† #: _____ Group NPI† #: _____

Office contact: _____ Contact phone: _____ Contact fax: _____

If you are a resident of a US state that provides certain rights with respect to your personal information, a complete description of the personal information we may collect and process, the purposes for which it is used by Genentech, and your rights under your state's privacy laws concerning your personal information can be found in our privacy notice at www.gene.com/privacy-policy.

Step 7 Health Care Provider Certification

By submitting this form, I certify: (a) The above therapy is medically necessary for this patient and the treatment decision has been made by the prescribing physician; (b) If the indication for which I am prescribing a Genentech product is not listed in the FDA-approved label, I am prescribing the medication for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication for such a use; (c) I received the authorization to release the information above and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy, or other contractors for the purpose of requesting reimbursement support, assisting in initiating or continuing therapy, as a break in treatment would negatively impact the patient's therapeutic outcome; (d) My patient meets the criteria for the Genentech Patient Foundation and to the best of my knowledge, this patient has no prescription insurance coverage (including Medicaid, Medicare, or other public or private programs) for the Genentech medicine listed above, or is unable to afford the cost-sharing requirements associated with his/her insurance coverage for this medication. If the patient is enrolled in an insurance plan, the plan does not require the patient's application to the Genentech Patient Foundation and/or has not changed or hidden the patient's coverage for the Genentech medicine to make them appear to be underinsured and eligible for the Genentech Patient Foundation; (e) The services I am requesting on behalf of the patient may include benefits investigation (BI), prior authorization support (PA), co-pay card and co-pay assistance foundation referral; (f) No action on these services will be taken until the patient consent document has been received; (g) I must comply with all state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc; I understand that noncompliance with state-specific requirements could result in outreach to me; (h) My patient meets the criteria for Genentech Patient Foundation (GPF); (i) I understand that Genentech reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted; (j) I understand that the GPF does not provide free drug in the instance of an administrative error or a coverage restriction, such as a step edit. For certain products where the step edit may not be medically appropriate, as confirmed by the prescribing physician, the GPF may consider support following 1 level of appeal.

Sign, date & fax to (833) 387-9700

*Prescriber Signature — Dispense as Written (Original signature required) ___/___/___ *Date OR *Prescriber Signature — Generic Substitution Permitted (Original signature required) ___/___/___ *Date

†National Provider Identifier.

All trademarks and trade names are the property of their respective owners.

Signature

Be sure to check the signature authorization boxes on Step 3 (if applicable) and provide an original signature on Step 7 for the specialty pharmacy to dispense needed ancillary supplies for enteral administration of Evrysdi. MySMA Support will forward the Start Form to the specialty pharmacy for processing.

The Generic Substitution line is provided to qualify the form as a valid prescription in certain states to determine eligibility. Note that there is no generic version of Evrysdi.

Submit Page 6 by: **Completing it online** at **Evrysdi.com/Forms** **OR** **Faxing** to **(833) 387-9700**

THE MySMA SUPPORT™ TEAM

Providing You and Your Patients the Support and Information You Need

Partnership and Access Liaison (PAL): The local, main point of contact from Genentech who supports your patients.

- PALs are not part of your medical team and do not provide medical advice. A PAL will always direct patients to their health care providers for any questions about the patient's health and/or medical care

Neurological Rare Disease Account Managers (NRD AMs): The local, dedicated support resource for practices who answers questions about Genentech's approved products and services. This can include answering:

- Evrysdi® (risdiplam) clinical questions
- General reimbursement and insurance questions
- Evrysdi Start Form questions
- Evrysdi Bridge Program questions

Case Manager (CM): Partners closely with you and other members of the MySMA Support team to help your patients understand the health insurance process and identify potential financial support options for Genentech's approved products.

Specialty pharmacy (SP): A specialty pharmacy prepares and ships Evrysdi directly to patients. Although the SP is not a part of Genentech, it is an important part of the MySMA Support Team.*

The Evrysdi Starter Program: Patients facing a coverage delay may be eligible for the Evrysdi Starter Program. With this program, eligible patients can receive up to an ~30 day supply of Evrysdi. If the patient continues to experience a coverage delay, the patient may be eligible for one refill (up to an ~30 day supply) of Evrysdi.

*Specialty pharmacies are not part of Genentech and maintain independence in their operations and in their role as a health care provider.

To learn more: **Visit** Evrysdi-HCP.com | **Call** MySMA Support at (833) 387-9734 Monday through Friday, 9 a.m.–8 p.m. ET

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