(vismodegib) capsule



M-US-00006688(v2.0)



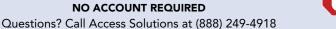


SUBMIT ONLY REQUESTED DOCUMENTS



Save time by submitting this form online below:

Quick Enroll





| Step 1 Pat | tient Information | | | |
|---|--------------------------------------|------------------------------------|--|--|
| Services Requested (Check all that apply): Benefits Investigation/ Prior Authorization Refer Patient to | *Date of birth (MM/DD/YYYY): Street: | *Last name / / Gender: [*State: | Apt: | |
| Co-pay Assistance Appeals Support | | | Do not contact patient ☐ Spanish ☐ Other: | |
| Is the patient insured? | | ch a copy of the patient's insuran | | |
| | Primary Insurance | Secondary Insurance | Pharmacy Benefit | |
| Insurance name | | | | |
| Subscriber name (if not pat | ient) | | | |
| Subscriber/Policy ID # | | | | |
| Group # | | | | |
| Insurance phone | | | | |

Step 3

Erivedge® (vismodegib) Co-pay Program Enrollment

☐ By checking this box, I certify that:

- I have the patient's consent to enroll in the Genentech Oncology Co-Pay Assistance Program for assistance with drug out-of-pocket costs and / or Genentech Oncology administration out-of-pocket costs
- The patient is not using and you will not bill any federal or state-funded health care program. This includes, but is not limited to, Medicare, Medicaid, Medigap, VA, DoD and TRICARE
- The patient is not currently receiving Genentech Oncology drugs from the Genentech Patient Foundation
- The patient is not currently receiving assistance from any other charitable organization for any of their out-of-pocket costs that are covered by the Genentech Oncology Co-pay Program
- Genentech reserves the right to rescind, revoke or amend the program without notice at any time.
- I have read and accepted the full Program Terms and Conditions as found on the following link: go.gene.com/oncology



Please continue to Step 4 on the next page

for *Erivedge*® Prescriber Service Form (vismodegib) capsule

SUBMIT ONLY REQUESTED DOCUMENTS

| Step 4 | Patient Information | (please re-enter) | | | | |
|---|--|---|---|---|--|--|
| *First name: | | *Last name: | * | DOB (MM/DD/YYYY): / / | | |
| Step 5 | Diagnosis and Clini | cal Information | | | | |
| *Primary ICD-10 Code: Secondary ICD-10 Code: | | *Metastat | Has patient started therapy? ☐ Yes ☐ No *Metastatic basal cell carcinoma? ☐ Yes ☐ No *Locally advanced basal cell carcinoma recurred following surgery, | | | |
| - | gib) capsule 150 mg | _ | or not a candidate for surgery, and not a candidate for radiation? | | | |
| □ 150 mg daily □ |] Other: | Dispense: | month supply Refi | ll times | | |
| Pharmacy and Shipp | ing Information: | | | | | |
| Specialty pharmacy: | | | | | | |
| Step 6 | Prescriber Informat | ion | | | | |
| *First name: | | | *Last name: | | | |
| | | | | | | |
| | | | | *City: | | |
| *State: | *ZIP: | Prescriber tax ID #: | | Prescriber NPI [†] #: | | |
| | | | | Contact email: | | |
| 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 https://www.gene.com/privacy-policy | | | | | | |
| Step 7 | Health Care Provid | er Certification | | | | |
| the prescribing phys you are prescribing t of this medication fo (as defined by the He the contracted dispe- continuing therapy, a reimbursement for fr above-named patien investigation (BI), be absence of a checkb taken until the patie | ician. (b) If the indication in the medication for an "unifor such a use. (c) I received ealth Insurance Portability ensing pharmacy, or other as a break in treatment we tee product provided to the the prescription describing its re-verification, prious selecting a service, we ent consent document here. | for which you are prescripproved" use, meaning the authorization to related and Accountability Act contractors for the purpould negatively impact the patient. I request General deciral authorization support (will perform BI/PA servas been received. (g) Formation and the patient of the patient of the services as been received. | ibing a Genentech product that the FDA has not appeared the information about of 1996 [HIPAA]) to Genepose of requesting reimble patient's therapeutic nentech Access Solution tes you are requesting or (PA), co-pay card and coices on behalf of the pation prescribers in states | and the treatment decision has been made by suct is not listed in the FDA-approved label, opproved the efficacy, dosage amount or safety ove and other protected health information sentech, Inc., Genentech Access Solutions, oursement support, assisting in initiating or outcome and (d) I will not attempt to seek as convey to the pharmacy chosen by the in behalf of the patient may include benefits pay assistance foundation referral. In the iient. (f) No action on these services will be with official prescription form requirements, long with this enrollment form. | | |
| Sign, date (877) 313 | | ber's Signature: (Orig | inal or stamped signature | *Date: / / e required) | | |

[†]National Provider Identifier.

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