

## Prescriber Service Form

Complete online by scanning QR code

Required Field (\*)

M-US-00006688(v2.0)



SUBMIT ONLY REQUESTED DOCUMENTS



Save time by submitting this form online below:

Quick Enroll

NO ACCOUNT REQUIRED

Questions? Call Access Solutions at (888) 249-4918



## Step 1

## Patient Information

Services Requested  
(Check all that apply):

- ☐ Benefits Investigation/  
Prior Authorization
- ☐ Refer Patient to  
Co-pay Assistance
- ☐ Appeals Support

\*First name: \_\_\_\_\_ \*Last name: \_\_\_\_\_

\*Date of birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: ☐ Male ☐ Female

Street: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ \*State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ ☐ Do not contact patientEmail: \_\_\_\_\_ Preferred language: ☐ English ☐ Spanish ☐ Other: \_\_\_\_\_

## Step 2

## Insurance Information

Is the patient insured? ☐ Yes ☐ No

If patient is uninsured, please complete the Genentech Patient Foundation Enrollment Form or call (888) 941-3331 for assistance.

If insured, please fill out the information below or attach a copy of the patient's insurance cards.

Is prior authorization in place? ☐ Yes ☐ No Auth #: \_\_\_\_\_

## Primary Insurance

## Secondary Insurance

## Pharmacy Benefit

| Insurance name                   |  |  |  |
|----------------------------------|--|--|--|
| Subscriber name (if not patient) |  |  |  |
| Subscriber/Policy ID #           |  |  |  |
| Group #                          |  |  |  |
| Insurance phone                  |  |  |  |

## Step 3

Erivedge<sup>®</sup> (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](http://go.gene.com/oncology)



Please continue to Step 4 on the next page

<sup>1</sup>National Provider Identifier.

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Phone: (888) 249-4918 | Fax: (877) 313-2659 | [Genentech-Access.com/Erivedge](http://Genentech-Access.com/Erivedge) | M-US-00006688(v2.0) 03/24

**Step 4****Patient Information (please re-enter)****\*First name:** \_\_\_\_\_ **\*Last name:** \_\_\_\_\_ **\*DOB (MM/DD/YYYY):** \_\_\_\_ / \_\_\_\_ / \_\_\_\_**Step 5****Diagnosis and Clinical Information****To the highest level of specificity, provide:****\*Primary ICD-10 Code:** \_\_\_\_\_

Secondary ICD-10 Code: \_\_\_\_\_

Has patient started therapy? ☐ Yes ☐ No**\*Metastatic basal cell carcinoma?** ☐ Yes ☐ No**Erivedge<sup>®</sup> (vismodegib) capsule 150 mg**☐ 150 mg daily ☐ Other: \_\_\_\_\_ Dispense: \_\_\_\_\_ -month supply Refill \_\_\_\_\_ times**\*Locally advanced basal cell carcinoma recurred following surgery, or not a candidate for surgery, and not a candidate for radiation?** ☐ Yes ☐ No**Pharmacy and Shipping Information:**Specialty pharmacy: ☐ Yes ☐ No Preferred specialty pharmacy: \_\_\_\_\_Onsite pharmacy: ☐ Yes ☐ No Onsite pharmacy: \_\_\_\_\_Ship to: ☐ Patient ☐ Practice ☐ Other: \_\_\_\_\_**Step 6****Prescriber Information****\*First name:** \_\_\_\_\_ **\*Last name:** \_\_\_\_\_**\*Practice name:** \_\_\_\_\_**\*Street:** \_\_\_\_\_ Suite: \_\_\_\_\_ **\*City:** \_\_\_\_\_**\*State:** \_\_\_\_\_ **\*ZIP:** \_\_\_\_\_ Prescriber tax ID #: \_\_\_\_\_ Prescriber NPI<sup>†</sup> #: \_\_\_\_\_Group NPI<sup>†</sup> #: \_\_\_\_\_ Office contact: \_\_\_\_\_ 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 Provider Certification**

**By signing 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 you are prescribing a Genentech product is not listed in the FDA-approved label, you are 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 and (d) I will not attempt to seek reimbursement for free product provided to the patient. I request Genentech Access Solutions convey to the pharmacy chosen by the above-named patient the prescription described herein. (e) The services you are requesting on behalf of the patient may include benefits investigation (BI), benefits re-verification, prior authorization support (PA), co-pay card and co-pay assistance foundation referral. In the absence of a checkbox selecting a service, we will perform BI/PA services on behalf of the patient. (f) **No action on these services will be taken until the patient consent document has been received.** (g) **For prescribers in states with official prescription form requirements, such as New York, prescriptions must be submitted on an official state prescription pad along with this enrollment form.**

Sign, date & fax to  
(877) 313-2659**\*Prescriber's Signature:** \_\_\_\_\_ **\*Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Original or stamped signature required)<sup>†</sup>National Provider Identifier.

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