GENENTECH PATIENT SUPPORT SERVICES

WILSERDLY™ Start Form
(giredestrant)

Patient Consent Form

How to submit
Send all completed pages via:
Fax: (877) 237-8919 **or**
Text a photo: (650) 877-1111 **or**
Scan QR code to complete digitally

1 Patient Information

First name: _____ Last name: _____

Date of birth (MM/DD/YYYY): ____/____/____ Email: _____

Cell phone: ( ) – Can we leave a detailed message? ☐ Yes ☐ No

Preferred language ☐ English ☐ Spanish ☐ Other: _____

Alternate contact (optional) Who should we contact if we can't reach you?

Full name: _____ Relationship to patient: _____ Phone: ( ) –

☐ Check this box **to receive free disease education, patient stories, financial support options and other materials tailored to my treatment journey and about other products and services from Genentech, its affiliates and its service providers.**

It may be necessary to use my personal health information to provide me with these materials. I understand that providing this is voluntary and plays no role in getting services or my medicine. I may withdraw my consent at any time by calling **(877) 436-3683**.

☐ Check this box **to receive the materials described above directly to my phone (call or text) from and on behalf of Genentech at the phone number(s) I have provided on this form.**

I understand that I do not need to agree to receive calls/texts as a condition of receiving goods, services or my medicine. These communications may be made using an automatic dialing system or an artificial or prerecorded voice. Message frequency may vary. Message and data rates may apply. I may opt-out at any time by texting STOP or by calling **(877) 436-3683**.

2 Patient Support Services Terms and Conditions

By signing below, I agree to enroll in Genentech patient support services (the "Services") and authorize Genentech and its service providers to use and disclose my information, including sensitive personal information, for coverage verification, financial assistance, care coordination and other support services.

These Services are entirely voluntary, are not a condition of health care treatment or medication access and do not obligate my health care provider to prescribe Genentech products. I am not required to consent to this processing, but, if I do not consent, I will not be able to receive the Services. I may withdraw my consent at any time by calling **(877) 436-3683**. Genentech reserves the right to modify, pause or cancel these free Services at any time without notice. For information on your privacy rights, review the Genentech Privacy Policy at **www.gene.com/privacy-policy**.

3 Patient Signatures - BOTH SIGNATURES AND DATE ARE **REQUIRED**

3A. I agree to enroll in the **Services** outlined in Section 2.

Sign _____

Patient/legal representative if patient is <18 years old (Puerto Rico age <21)

Scan to save Genentech to your phone contacts.
Know it's us when we call.

3B. I agree to the **HIPAA Authorization for the Use and Disclosure of Health Information** outlined in Section 4.

Sign _____ **Date** ____/____/____

Patient/legal representative if patient is <18 years old (Puerto Rico age <21) (MM/DD/YYYY)

If signed by legal representative:

Printed name: _____ Relationship to patient: _____

HIPAA=Health Insurance Portability and Accountability Act.

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4 HIPAA Authorization for the Use and Disclosure of Health Information

Who is sharing my information, and what are they sharing?

I give my health care providers (my doctors, their staff, my pharmacies, lab service providers and my health insurance plan) permission to disclose and redisclose my protected Health Information (collectively, "Health Information"). This includes my contact details, basic facts about me, financial information and details about my health, medical treatments and insurance.

Who is receiving my information?

My health care providers may share this information with Genentech, USA Inc., the Genentech Patient Foundation, and their partners, affiliates, service providers and agents (collectively called "Genentech").

Why is my information being shared?

I'm authorizing Genentech to receive, use, share and re-share my Health Information so that I can enroll and participate in Genentech patient support services (the "Services"). I give Genentech permission to collect, use, share and re-share my Health Information to:

- Sign me up for the Services and, if applicable, process my application for the Genentech Patient Foundation
- Check if I can get financial assistance, such as co-pay help, and help me sign up for it, if I qualify
- Communicate with my health care providers to help understand or check my coverage for Genentech products
- Monitor for safety and quality and to improve Genentech products and services
- Contact me by mail, email, text or phone using the information I gave on this form for purposes related to my participation in the Services, including to discuss my coverage, costs and whether I can get financial assistance and to send Services-related resources
- Support internal Services operations, analytics and improvement, including to manage my relationship with Genentech and personalize my Services
- Help me get my Genentech products
- Meet and support Genentech's legal and compliance purposes

I understand that Genentech may also share my Health Information, including sensitive Health Information, for these same purposes with my health care providers, service providers and any alternate contact I have listed.

Important things I understand

- **My Choice:** I do not have to sign this authorization. My health care providers cannot make me sign this to receive treatment, payment or insurance benefits. However, Genentech cannot provide the Services to me without my signature
- **Provider Payment:** My health care providers might receive payment or remuneration for sharing my Health Information for these Services
- **Privacy Protections:** Once my Health Information is shared under this authorization, it may no longer be protected by state and federal laws like HIPAA and the recipient could redisclose it. However, Genentech will only use and share it for the purposes listed here or as the law permits

Continued on page 3

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4 HIPAA Authorization for the Use and Disclosure of Health Information (continued)

My rights

- **How long this lasts:** This authorization is valid for **6 years** from the date I sign it or the date I last enrolled (whichever comes first), unless the law requires a shorter time. If I live in Maryland or California, this authorization is valid for **1 year** from the date I sign
- **How to cancel:** I have the right to cancel (revoke) this authorization at any time by calling **(866) 422-2377** or submitting a written notice to: Genentech Access Solutions, 1 DNA Way, South San Francisco, CA 94080-4990
- **What happens if I cancel:** If I cancel, I will no longer be eligible for the Services described. The cancellation takes effect when my health care providers receive notice of it, but it will not undo any sharing of my information that has already happened
- **Getting a copy:** I have the right to receive a copy of this authorization. I can request a copy at any time by calling the number or writing to the address listed above
- **More privacy info:** I can read more about my privacy rights, including specific state rights, in Genentech's privacy policy at **www.gene.com/privacy-policy**

5 Genentech Patient Foundation Eligibility - Complete only if applying for financial assistance

The Genentech Patient Foundation gives free medicine to people who are uninsured, are insured without coverage or with financial concerns and meet eligibility criteria.

To determine your eligibility, complete this section acknowledging that you have provided accurate, complete information and agree to the terms and conditions below.

How many people live in your household? Include yourself, your spouse, and any legal dependents for whom you are financially responsible.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

What is your annual household income before taxes? **$** _____

6 Genentech Patient Foundation Terms and Conditions

- **My responsibilities:** If I receive free medicine from the Genentech Patient Foundation, I will not sell or give out the medicine because it is illegal to do so. I am responsible to ensure that the medicine is sent to a secure address when shipped to me and I must control any medicine that I receive
- **Income verification and audit:** I understand that, for purposes of an audit, the Genentech Patient Foundation may ask me for a copy of my IRS 1040 Form or other proof of income
- **Alternative funding programs:** Some insurance plans and/or employers partner with organizations known as alternate funding programs. Such arrangements require patients to apply to the Genentech Patient Foundation as a condition of, or prerequisite to, coverage of relevant Genentech products. These alternate funding programs include SHARx, Paydhealth and Payer Matrix, among others. Patients whose insurance plans and/or employers use an alternative funding program are ineligible for support from the Genentech Patient Foundation
- **Employer and insurance plan attestations:** I acknowledge that, to the best of my knowledge, neither my insurance plan nor my employer (1) required me to apply to the Genentech Patient Foundation and/or (2) changed or hid my insurance coverage for my Genentech medicine to make me appear to be underinsured and eligible for support from the Genentech Patient Foundation. I am not applying to the Genentech Patient Foundation on behalf of someone whose insurance plan and/or employer partners with an alternative funding program. The Alternate Contact listed on my application (if any) is not associated with or a representative of my insurance company, employer or a business partner of my insurance company or employer. If I subsequently learn that my insurance plan and/or employer uses an alternative funding program, I agree to inform the Genentech Patient Foundation immediately and understand that I will no longer be eligible for support

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Save time—complete this form online.
Visit Genentech-Pro.com/Enrollment or log in to My Patient Solutions® for Health Care Practices.

QUESTIONS?
Call WILSERDLY Access Solutions at (888) 249-4918.

SUBMIT ONLY REQUESTED DOCUMENTS **Required field**

Prescriber Form (to be filled out by the HCP)

Step 1 Patient Information

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

Date of birth (MM/DD/YYYY): ____/____/____ Gender: ☐ Male ☐ Female

Street: _____ Apt: _____ **City:** _____

State: _____ **ZIP:** _____ **Phone:** _____ Phone type: ☐ Cell ☐ Home

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

Alternate contact name: _____ Relationship: _____ Alt. phone: (____) ____-____

Step 2 Insurance Information

Does the patient have health insurance? ☐ Yes ☐ No Is PA in place? ☐ Yes ☐ No Auth #: _____

If patient is uninsured, ensure Section 5 of the Patient Consent Form (page 3) is completed by your patient.
If insured, please fill out the information below or attach a copy of the front and back of the patient's insurance card(s).
The Genentech Patient Foundation requires documentation to make eligibility determination, including and not limited to, insurance cards, insurance approval and denial information.

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

Step 3 Prescriber Information

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

Practice name: _____ **Street:** _____

Suite: _____ **City:** _____ **State:** _____ **ZIP:** _____

Prescriber Tax ID #: _____ Prescriber NPI #: _____ Group NPI #: _____

Office contact: _____ Office contact email: _____

Office contact phone: (____) ____-____ Office 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 4 Genentech Co-pay Program for WILSERDLY Enrollment for Patients With Commercial Insurance ONLY

☐ **By checking this box, I certify:** I have the patient's consent to enroll in the Genentech Co-pay Program for WILSERDLY for assistance with drug 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 WILSERDLY 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 Co-pay Program for WILSERDLY. 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: **www.genentechcopay.com**.

Genentech medicines and FDA-approved indications list: **www.gene.com/medical-professionals/medicine**

Please continue to **Step 5** on the next page

DoD=US Department of Defense; FDA=US Food and Drug Administration; HCP=health care professional; NPI=National Provider Identifier; PA=prior authorization; Rx=prescription; VA=US Department of Veterans Affairs.

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Save time—complete this form online. Visit Genentech-Pro.com/Enrollment or log in to My Patient Solutions® for Health Care Practices.

QUESTIONS? Call WILSERDLY Access Solutions at (888) 249-4918.

SUBMIT ONLY REQUESTED DOCUMENTS **Required field**

Prescriber Form (to be filled out by the HCP)

Step 5 Patient Information (please re-enter)

First name: _____ **Last name:** _____ **Date of birth** (MM/DD/YYYY): ___/___/_____

Step 6 REQUIRED WILSERDLY Prescription Information

	WILSERDLY Therapy	Size/Strength	Dosing	Quantity	Refills
☐	In combination with everolimus, for the treatment of adults with ER+, HER2-, *ESR1*-mutated locally advanced or metastatic breast cancer, as detected by an FDA-authorized test, whose disease has recurred during or after completion of endocrine-based adjuvant therapy, or has progressed on at least one endocrine-based regimen in the metastatic setting.	30 mg	By mouth once daily, with or without food, in combination with everolimus 10 mg	28 capsules	____
☐	Other WILSERDLY-based therapy. List cancer therapies prescribed in combination with WILSERDLY: _____	30 mg	By mouth once daily, with or without food	28 capsules	____

Other supportive care medications or attach medication list: _____

Dispensed through: ☐ Onsite pharmacy ☐ Specialty pharmacy Preferred pharmacy name: _____

(Complete at highest level of specificity):

Primary diagnosis code: _____ Has the patient started therapy? ☐ Yes ☐ No

Secondary diagnosis code: _____ First treatment date (MM/DD/YYYY): _____

☐ Drug and non-drug allergies: _____ ☐ No known allergies **Clinical trial participant?** ☐ Yes ☐ No

WILSERDLY Bridge Program

The WILSERDLY Bridge Program provides temporary, free medication to eligible patients prescribed WILSERDLY who experience a coverage delay or gap of insurance. Please vist **Genentech-Pro.com/WILSERDLY-Bridge-Terms** for **full eligibility requirements** and terms and conditions or speak to your WILSERDLY representative for more information. You can also call WILSERDLY Access Solutions at (888) 249-4918 to learn more.

WILSERDLY Bridge Program - please check the box below to enroll patient

☐ I attest my patient has been prescribed WILSERDLY for an FDA-approved indication. I understand the eligibility requirements, including, in the event of a denial, submission of an appeal will be required and my office will not attempt to seek reimbursement for free product provided to the patient. Genentech reserves the right to rescind, revoke or amend the Program without notice at any time.

Step 7 Health Care Provider Certification

By submitting this form, I certify: (a) Medical Necessity: The prescribed therapy is medically necessary and the treatment decision was made by the prescribing physician. **(b)** FDA Status: If the medication is prescribed for a use not on the FDA-approved label, I acknowledge the FDA has not approved the efficacy, dosage or safety for such non-indicated use. **(c)** PHI Authorization: My office has received authorization to release the patient's protected health information (PHI) to Genentech, Inc., Genentech Access Solutions, the contracted dispensing pharmacy or other contractors for the purpose of requesting and its partners to assist with reimbursement and therapy initiation. **(d)** Reimbursement: My office will not attempt to seek reimbursement for free product provided to the patient. **(e)** Genentech Patient Foundation Eligibility: 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. **(f)** Genentech Patient Foundation Restrictions: I understand that the Genentech Patient Foundation 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 Genentech Patient Foundation may consider support following 1 level of appeal. **(g)** Service Request: I am requesting services including benefits investigation, prior authorization, appeals support and co-pay referrals. **(h)** Consent & Compliance: No action will be taken until patient consent is received. I will comply with all state-specific prescription requirements (e.g., e-prescribing, specific forms). **(i)** Program Rights: I acknowledge Genentech's right to verify submitted information or modify/discontinue this program at any time.

Step 8 Prescriber's Signature Required

By signing this form, I certify: (a) - **(i)** in Step 7 and: **(j) 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) 237-8919

_____ _____

Prescriber's Signature: (Original signature required) **Date signed:** (MM/DD/YYYY)

Complete pages 4-5 and submit pages 1, 3-5 to WILSERDLY Access Solutions via fax to **(877) 237-8919**. You can also submit via My Patient Solutions® for Health Care Practices or online at **Genentech-Pro.com/Enrollment**. **Pages 1 and 3** can also be submitted by text to **(650) 877-1111**.

ER+=estrogen receptor-positive; *ESR1*=estrogen receptor 1; HER2-=human epidermal growth factor receptor 2-negative.

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