

STATEMENT OF MEDICAL NECESSITY (SMN) for Genentech BioOncology Access Solutions



Phone: (888) 249-4918 Fax: (888) 249-4919 BioOncologyAccessSolutions.com

Please note - ALL fields denoted with an asterisk (*) are required fields.



Services Requested* (check all that apply)

- Benefits Investigation/Prior Authorization Appeals Support
 Co-pay Assistance GATCF[†] Patient Assistance
 GATCF Eligibility Screening

Patient Information

Last name*: _____ First name*: _____
Birth date*: _____ Gender*: Male Female
Street: _____
City: _____ State*: _____ ZIP: _____
Home phone: _____
Work/cell phone: _____ Email: _____
OK to contact patient? Yes No
Alternate contact last name: _____
First name: _____
Relationship to patient: _____
Alternate contact phone: _____
Is patient deceased? Yes No

Insurance Information

No insurance
Is the patient pending Medicaid determination? Yes No Pending
Please attach a copy of the patient's insurance card

Primary insurance (PI) name: _____
PI phone: _____
PI subscriber name: _____
PI subscriber ID #: _____
Policy/group #: _____

Secondary insurance (SI) name: _____
SI phone: _____
SI subscriber name: _____
SI subscriber ID #: _____
Policy/group #: _____

Oral Oncologic Pharmacy Preference

Specialty Retail Onsite pharmacy/Physician dispenser
Pharmacy name: _____
Phone: _____
Contact person: _____

Clinical Trial Patient

Clinical Trial Patient? Yes No

If Yes, study site: _____
Study #: _____
Clinical coordinator: _____
Phone: _____

*Required field. Genentech BioOncology Access Solutions cannot process your SMN unless these fields are completed.
[†]Genentech[®] Access to Care Foundation. [‡]National Provider Identifier. [§]Provider Transaction Access Number.

Prescriber Information

Facility/practice name: _____
Prescriber's last name*: _____
First name*: _____
Specialty: Oncologist Other (specify): _____
Prescriber license #: _____
Street*: _____
City*: _____ State*: _____ ZIP*: _____
Clinical/Medical contact: _____
Phone: _____ Fax: _____
Reimbursement contact: _____
Phone: _____ Fax: _____
Billing information for: Group Individual
Tax ID #: _____
NPI# #: _____
PTAN[§] #: _____
DEA #: _____

Patient Medical Information

Indicate patient's therapy (check all that apply):

AVASTIN[®] (bevacizumab) Herceptin[®] (trastuzumab)
 Rituxan[®] (rituximab) Tarceva[®] (erlotinib) XELODA[®] (capecitabine)
Has treatment started? Yes No Date: _____

Place of administration:

Physician's office Hospital outpatient Hospital inpatient
Primary ICD-9-CM code*: _____ Description: _____
(required to the highest level of specificity)

Secondary ICD-9-CM code: _____ Description: _____
Date of diagnosis: _____

Clinical TNM stage:

0 I IIA IIB IIIA IIIB IIIC IV

Line of therapy (required):

First Second Other

Previous treatment:

None Hormone therapy Radiation
 Surgery Other: _____
Chemotherapy (please specify): _____

Concurrent treatment prescribed with Genentech product (required): _____

If applicable, HER2 Positive? Yes No
Test results: FISH (ratio) _____ IHC _____ 1+ _____ 2+ _____ 3+ Other: _____

Adjuvant: Yes No

► For Rituxan Patients Only

Disease Characteristics:

Indolent Aggressive CD20-positive

PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION (PAN)

Genentech
BIOONCOLOGY™

Access Solutions™
Treatment made possible.

Phone: (888) 249-4918 Fax: (888) 249-4919 BioOncologyAccessSolutions.com

Genentech BioOncology Access Solutions is a free program for you from Genentech.

We work to help you pay for your Genentech product. We can help in many different ways. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech products, we might be able to help. If you meet certain financial and medical standards, we can supply free medicine. This is done through the Genentech® Access to Care Foundation (GATCF).

For us to help, we need to look at, use and disclose your personal health information (PHI). Your doctor and health care plan may disclose your PHI to us only with your written consent. Once you sign this form and it is sent back to us, we can start to provide these services. We can provide you with a copy of this release. You need to ask us for this first before we can send the copy back to you.

You do not have to agree to this authorization. But we cannot provide our services without your consent. This means you might need to pay for certain medicines on your own.

PLEASE READ THROUGH THIS FORM CAREFULLY. IF YOU HAVE ANY QUESTIONS, TALK TO YOUR DOCTOR'S OFFICE OR CALL US AT THE PHONE NUMBER LISTED AT THE TOP OF THIS PAGE.

1. Information to Be Disclosed or Used

This signed form lets my doctors and health care plans send my PHI to Genentech BioOncology Access Solutions and/or GATCF. This includes:

- All my health records relating to my treatment
- Information about my health care plan benefits
- The dollar balance left on the total of the lifetime payments covered by my health care plan policy (if this applies to my plan)
- Any information having a bearing on my health or my adherence to my treatment

All of the above is considered part of my PHI. I know this could include information about:

- Sexually transmitted diseases
- Mental health conditions
- Genetic test results

We are not looking for this information. It might be part of the medical record sent to us.

2. Who May Disclose My PHI

My PHI may be released by my doctor. It may also be released by my health care plan or others who might hold my PHI.

3. Who May See My Personal Health Information (PHI)

My PHI may be seen by Genentech BioOncology Access Solutions and/or GATCF. These are programs sponsored by Genentech. Its address is 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. It may also be seen by anyone helping Genentech BioOncology Access Solutions perform services including Genentech employees and any of Genentech's partners.

4. How My PHI May Be Used

My PHI may be used only in these ways:

- Helping with my health care plan coverage for Genentech products
- Applying to GATCF
- Tracking my use of Genentech products
- Measuring the help offered by Genentech BioOncology Access Solutions

5. Expiration Date

This release is in effect for 1 year once I have signed it. I may also withdraw it in writing at any time.

6. Notices

Once I sign this form, I know my PHI might not be covered by any federal law about the use of my PHI or how it is disclosed. There is no guarantee my PHI might not be released to a third party. This third party might not need to follow the conditions of this release.

I know I can refuse to sign this form. I may withdraw it at any time and for any reason. This won't affect the start or continuing of my treatment. It will have no effect on the quality of my treatment.

I know this release stays in effect for 1 year or until I withdraw it in writing. To withdraw it, I must send a written notice to Genentech. It can be sent by fax or by mail to the address at the bottom of this page. This withdrawal goes into effect once it is received by Genentech. It will have no impact on my treatment by my doctor.

If I don't sign this form or withdraw it, I may be responsible for the costs of my treatment.

7. Distribution Acceptance

If I receive free product from GATCF, I will use Genentech products as my doctor has prescribed them to me. I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

SECTION 8 ON THE NEXT PAGE IS REQUIRED.

This written notice must be signed, dated and mailed or faxed to:

Genentech BioOncology Access Solutions
1 DNA Way, Mail Stop #858a
South San Francisco, CA 94080-4990

Fax: (888) 249-4919

