

## Instructions for Patients

### By completing this form, you can:



**Learn** about your health insurance coverage and other options to get your Genentech medicine



**Sign up** to receive **optional** disease education and other material

### Please follow these 3 steps to get started:

1. Read “Authorization to Use and Disclose Personal Information” on page 3.
2. Sign and date page 4. Please note you must sign the form to get support for your treatment.
3. Send in your completed form using one of the options below.

Genentech can start helping you when page 4 of this form is submitted by you or your doctor’s office in one of the following ways:



**Complete online** by scanning this QR code or visiting **OCREVUS.com/Forms**

OR



**Print, complete, take a photo and text** it to (650) 877-1111

OR



**Print, complete and fax** it to (877) 312-2193

A representative from OCREVUS Access Solutions or your doctor’s office will call you to tell you about your coverage, costs and support for your treatment.

If you have any questions, talk to your health care provider or call OCREVUS CONNECTS at (844) 627-3887.

## Instructions for Health Care Providers

Please write legibly and complete all required fields (\*) on the OCREVUS Start Form to prevent delays.



**By completing this form, you are requesting services on behalf of your patient, which may include:**

- Benefits investigation
- Benefits reverification approximately 6 weeks prior to patient’s next treatment date
- Infusion site identification
- Assistance with the prior authorization process and appeals resources
- Referral to co-pay support options or Genentech Patient Foundation services (please check the appropriate boxes on behalf of your patient)

**You may opt out of any of these services** for your patient by contacting OCREVUS CONNECTS at (844) 627-3887.



**To enroll your patient, please follow these steps:**

- Have your patient read pages 2 and 3
- Have your patient complete page 4
- Complete page 5
- Send pages 4 and 5 via one of the following options:
  - My Patient Solutions<sup>®</sup> for Health Care Practices at **Genentech-Access.com/MPS**
  - eSubmit at **OCREVUS.com/Forms**
  - Fax at (877) 312-2193

Page 4 can also be sent via text according to the instructions above.

**Diagnosis Code and Clinical Information:** Enter the diagnosis code to the highest level of specificity.

**Infusion Site Location:** Check the appropriate box to indicate the need for assistance with infusion site identification.

## Helpful Terminology

**Genentech:** The maker of the medicine your provider wants to prescribe for you. Genentech is committed to helping patients get the medicine their provider prescribed. When used on this form, the term “Genentech” refers to Genentech, Genentech Patient Foundation, and their respective partners, affiliates, subcontractors and agents.

**Genentech Access Solutions:** A team at Genentech that works with your doctor and health insurance plan to help you get your medicine.

**Genentech Patient Foundation:** A program that gives free Genentech medicine to eligible people who don't have insurance coverage or who have financial concerns.

**Patient Navigator:** Your personal guide throughout your treatment with a Genentech medicine. They will take you through the process and help you along the way.

**Household size:** Number of people living in your household, including you.

**Annual household income:** How much you and the members of your household make each year, minus specific deductions. This is also frequently referred to as your adjusted gross income or AGI. This information is needed to determine Genentech Patient Foundation eligibility.

**Patient education and treatment resources: Optional** programs offered by Genentech to help you start and stay on your medicine. Services may vary based on your medical condition and could include co-pay assistance, clinical support, marketing communication and general disease information.

**Deductible:** The amount you pay for health care services or medicines out of pocket before your health insurance plan begins to pay.

**Out-of-pocket costs:** The amount not paid by the insurance plan that you must pay for your treatment. This includes deductibles, co-pays and co-insurance.

**Co-pay assistance:** Programs available to help eligible patients pay for their medicines.

**Alternate contact:** Someone you choose to be your contact person if Genentech Access Solutions cannot reach you.

**Legally authorized representative:** An individual or judicial or other body authorized under applicable law to consent on behalf of a patient (e.g., a parent or legal guardian of a minor).

## Terms and Conditions of the Genentech Patient Foundation

- If I receive free medicine from the Genentech Patient Foundation, I will not sell or give out this 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
- I understand that, for purposes of an audit, the Genentech Patient Foundation could ask me for a copy of my IRS 1040 form or other proof of income

## Authorization to Use and Disclose Personal Information

I authorize my physician(s) and their staff, pharmacies, and health insurance plan (my “health care providers”) to share my personal information, which may include contact information, demographic information, financial information, and information related to my medical condition, treatments, and health insurance and benefits, with Genentech, Genentech Patient Foundation, and their respective partners, affiliates, subcontractors, and agents (together, “Genentech”). I authorize Genentech to receive, use, and share my personal information in order to provide me with access to the products, services, and programs described on this form, which may include the following:

- Working with my health insurance plan to understand or verify coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility for and facilitating enrollment into financial assistance services if I’m eligible, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider’s office. This includes contacting me to discuss my coverage, costs and eligibility for assistance and other program administration purposes
- Facilitating my access to Genentech products
- Ensuring quality and safety and improving our products and services
- Contacting me by mail, e-mail, telephone calls and text messages at the number(s) and address(es) provided for non-marketing purposes
- If I agree to the **optional** Consent for Patient Resources and Information, providing me with **optional** disease information and marketing material about products, services and programs offered by Genentech, its partners and their respective affiliates. This is not required to enroll into Genentech Access Solutions services
- If I agree to the **optional** Telephone Consumer Protection Act (TCPA) Consent, contacting me by autodialed calls and/or text messages at the phone number(s) I have provided for marketing purposes. This is not required to enroll into Genentech Access Solutions services

I understand that Genentech may also share my personal information for the purposes described on this authorization with my health care providers, service providers, and any individual I may designate as an alternate contact. I understand that my pharmacy may receive remuneration for disclosing my personal information pursuant to this authorization. I can choose not to sign this authorization, but Genentech will not be able to provide the services to me without it. However, my health care providers may not condition either my treatment or my payment, enrollment, or eligibility for benefits on signing this authorization.

I also understand and agree that:

- This authorization is valid for 6 years from the date I sign or the date I last enrolled, whichever comes first, unless a shorter period is required by law, or I revoke it earlier
- My personal information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Genentech will only use and share my personal information for the purposes stated on this authorization or as otherwise permitted by law
- I have the right to revoke (cancel) this authorization at any time by submitting a written notice to: Genentech Access Solutions, 1 DNA Way, South San Francisco, CA 94080-4990. If I revoke this authorization, I will no longer be eligible for the services described. If a health care provider is disclosing my personal information to Genentech on an authorized, ongoing basis, my revocation will be effective with respect to such health care provider when they receive notice of my revocation. My revocation will not impact uses and disclosures of my personal information that have already occurred in reliance on this authorization
- More information on my privacy rights, including specific rights I may have as a resident of certain states, like California, can be found in Genentech's privacy policy ([www.gene.com/privacy-policy](http://www.gene.com/privacy-policy))
- I have a right to receive a copy of this authorization

## 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: ( ) -

### Financial Eligibility: Complete **only** if you are applying to the Genentech Patient Foundation

1

By completing this section, I am agreeing to the Terms and Conditions of the Genentech Patient Foundation outlined on page 1.

Household size (including you): \_\_\_\_\_ Annual household income:  Under \$75,000  
 \$75,000 – \$100,000  \$100,001 – \$125,000  \$125,001 – \$150,000  Over \$150,000

### Consent for Patient Resources and Information (OPTIONAL)

Genentech offers **optional** and free disease education and other material for patients. This may include information and marketing material about products, services and programs offered by Genentech, its partners and their respective affiliates. If you sign up, you may be contacted using the information you have provided.

2

By checking this box, I agree to receive **optional** disease education and other material. I understand providing this agreement is voluntary and plays no role in getting Genentech Access Solutions services or my medicine. I also understand that I may opt out of receiving this information at any time by calling **(877) 436-3683** and that this consent will remain active unless I opt out.

### Telephone Consumer Protection Act (TCPA) Consent (OPTIONAL)

By checking this box, I consent to receive autodialed marketing calls and text messages from and on behalf of Genentech at the phone number(s) I have provided. I understand that consent is not a requirement of any purchase or 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)**.

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 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 \*Date signed  
(A parent or guardian must sign for patients under 18 years of age) (MM/DD/YYYY)

Person signing (if not patient)

Print first name Print last name Relationship to patient

Once this page (4/5) has been completed, please text a photo of the page to **(650) 877-1111**, or fax to **(877) 312-2193**. You can also complete this form online at **Genentech-Access.com/PatientConsent**.

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.

**Prescriber Service Form**—to be filled out by health care provider

**STEP 1** Patient Information  DO NOT CONTACT PATIENT

First name\* Last name\* Date of birth\* (MM/DD/YYYY) Gender:  Male  Female

Street City State\* ZIP Phone\*

**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 front and back of the patient's insurance card(s).

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

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

**STEP 3** Prescriber Information  Buy and bill  Specialty pharmacy

First name\* Last name\* Practice name\*

Street\* Suite # City\* State\* ZIP\*

Prescriber tax ID # Prescriber NPI # Group NPI #

Office contact name Office contact phone Fax

**STEP 4** Infusion Site Location  Please provide assistance locating an infusion site for patient.  Prescriber's office (STEP 3).

Preferred infusion site name Infusion site tax ID # Infusion site NPI #

Street Suite #

City State ZIP Phone Fax

**STEP 5** Diagnosis Code and Clinical Information

Diagnosis code\*:  G35 Multiple Sclerosis (MS)  Relapsing Forms of MS (RMS)  Primary Progressive MS (PPMS)  
 Other diagnosis code: \_\_\_\_\_

**BY SUBMITTING THIS FORM:**

I am requesting services on behalf of the patient, which may include benefits investigation and reverification, help navigating the PA process and appeals support.

**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 this Genentech product is being prescribed to treat is not listed in the FDA-approved label, the prescriber is 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) The provider's office 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) The provider's office will not attempt to seek reimbursement for free product provided to the patient. (e) The services requested on behalf of the patient may include benefits investigation (BI), prior authorization (PA) and appeals support, 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.**

NPI=National Provider Identifier.