Genentech | Access Solutions
A Member of the Roche Group

Oncology

Prescriber Service Form

Complete online by scanning QR code

Required Field (*)

Submit Only Requested Documents

Save time by submitting this form online with Quick Enroll

NO ACCOUNT REQUIRED

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

Step 1 Services Requested
(Check all that apply)

☐ **Benefits Investigation/Prior Authorization** ☐ **Co-pay Referrals** ☐ **Appeals Support**

Step 2 Patient Information

***First Name:** _____ ***Last Name:** _____ ***DOB (MM/DD/YYYY):** ____/____/____

Street: _____ Apt: _____ Gender: ☐ Male ☐ Female

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

Phone: (_____) _____-_____ Phone Type: ☐ Cell ☐ Home ☐ Do not contact patient

Email: _____ Patient Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Alternate Contact Name: _____ Relationship: _____ Alt Phone: (_____) _____-_____

Step 3 Insurance Information

Is the patient insured? ☐ Yes ☐ No Is PA in place? ☐ Yes ☐ No Auth #: _____

If patient is uninsured or without any form of health insurance please complete the Prescriber Foundation Form here Quick Enroll or call (888) 941-3331 for assistance. If insured, please fill out the information below or attach a copy of the patient's health insurance cards.

	Primary Insurance	Secondary Insurance	PBM/RX Insurance (Needed for Orals)
Insurance Name			
Subscriber Name (if not patient)			
Subscriber ID			
Policy/Group #			
Insurance Phone #			

Step 4 Diagnosis and Clinical Information

Please complete all fields that apply to your patient to prevent enrollment delays

ICD-10 codes should be highest level of specificity:

***Primary ICD-10 Code:** _____.____

Secondary ICD-10 Code: _____.____

Has the patient started therapy? ☐ Y ☐ N

First Treatment Date: ____/____/____

***Line of Therapy:** ☐ 1L ☐ 2L ☐ 3L or later

Biomarker Status (Select all that apply)

☐ *PIK3CA*+

HER2 Status:

☐ HER2+ ☐ HER2-

Hormone Receptor (HR) Status:

☐ HR+

☐ ALK+

☐ PD-L1+

☐ ROS1+

☐ NTRK Fusion+

☐ Other:_____

Disease Stage

☐ Stage 0-3

☐ Metastatic

Treatment Setting

☐ Neo-adjuvant

☐ Adjuvant Therapy

Step 5 Oncology Co-Pay Program Enrollment for Patients with Commercial Insurance ONLY

☐ **By checking this box, I certify:** I have the patient's consent to enroll in the Genentech Oncology Co-Pay 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

Genentech Medicines & FDA Approved Indications List: https://www.gene.com/medical-professionals/medicines

Please **continue to Step 6** on the next page

Genentech | Access Solutions
A Member of the Roche Group

Oncology

Prescriber Service Form

Complete online: Quick Enroll

Complete online by scanning QR code

Required Field (*)

Submit Only Requested Documents

Step 6 Patient Information (please re-enter)

*First Name: _____ *Last Name: _____ *DOB (MM/DD/YYYY): ____/____/____

Step 7 Patient Cancer Medicine(s)

Genentech Oncology Medicine List: genentech-access.com/hcp/oncology

*Genentech Oncology Medicines Brand name only	*Formulation Type Please indicate infused (IV), oral, subcutaneous (SC) or other	ORALS ONLY: REQUIRED PRESCRIPTION INFORMATION			
		Size/Strength	Quantity	Frequency/Directions For weight-based medications, please include exact dose or patient weight	Refills

Clinical trial participant for this medicine? ☐ Yes

☐ Combination Therapy Benefits Investigation Combination Therapy Regimen Name: _____

OR list cancer therapies prescribed in combination with Genentech medicine(s) OR attach medication list: _____

_____

Where will medicines be administered? ☐ Physician's office ☐ HOPD ☐ Other (please specify): _____

Name: _____ Tax ID #: _____ NPI #: _____

Medication(s) dispensed through: ☐ Buy and bill ☐ Onsite pharmacy ☐ Specialty pharmacy (SP): _____

Step 8 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 https://www.gene.com/privacy-policy.

Step 9 Health Care Provider Certification

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 program referral or enrollment and co-pay assistance foundation referral. (f) No action on these services will be taken until the patient consent document has been received.

Step 10 ORALS ONLY Prescriber's Signature Required

By signing this form, I certify: (a) - (f) in Step 9 and: **(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)