Genentech | ACCESS SOLUTIONS®
A Member of the Roche Group

for Erivedge® (vismodegib) capsule 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 patient
Email: _____ 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® (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

Please continue to Step 4 on the next page

†National Provider Identifier.

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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**

***Locally advanced basal cell carcinoma recurred following surgery, or not a candidate for surgery, and not a candidate for radiation?** ☐ **Yes** ☐ **No**

Erivedge® (vismodegib) capsule 150 mg

☐ 150 mg daily ☐ Other: _____ Dispense: _____ -month supply Refill _____ times

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† #: _____

Group NPI† #: _____ 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)

†National Provider Identifier.