(vismodegib) capsule



Required Field (\*)



# for *Erivedge®* Prescriber Service Form

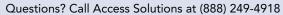
SUBMIT ONLY REQUESTED DOCUMENTS



### Save time by submitting this form online below:

**Quick Enroll** 

### NO ACCOUNT REQUIRED





Step 1 Pat	ient Information					
Services Requested (Check all that apply):  Benefits Investigation/ Prior Authorization  Refer Patient to Co-pay Assistance	*Date of birth (MM/DD/YYYY):	Gender: □ Male □				
	City:	*State:	ZIP:			
☐ Appeals Support		ome phone: () Cell phone: () Do not contact patiennail: Preferred language: Description				
Is the patient insured?			all (888) 941-3331 for assistance.			
	Primary Insurance	Secondary Insurance	Pharmacy Benefit			
Insurance name						
Subscriber name (if not pati	ient)					
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



for *Erivedge*® Prescriber Service Form (vismodegib) capsule

SUBMIT ONLY REQUESTED DOCUMENTS

Step 4	Patient Information	(please re-enter)			
*First name:		Last name:		DOB (MM/DD/YYYY):	/ /
Step 5	Diagnosis and Clinic	al Information			
To the highest level of specificity, provide:  *Primary ICD-10 Code:  Secondary ICD-10 Code:		*Metastati	Has patient started therapy? ☐ Yes ☐ No  *Metastatic basal cell carcinoma? ☐ Yes ☐ No  *Locally advanced basal cell carcinoma recurred following surgery,		ery,
Erivedge® (vismodegi				nd not a candidate for radiation	on? ☐ Yes ☐ No
☐ 150 mg daily ☐		Dispense:	month supply Re	ill times	
Pharmacy and Shippin					
-		-			
Ship to: ☐ Patient ☐	Practice Dother:				
Step 6	Prescriber Informati	on			
			*Last name:		
				Prescriber NPI <sup>†</sup> #:	
				Contact email:	
· ·				) -	
personal information v	we may collect and proce	ess, the purposes for wh	ich it is used by Genen	formation, a complete descrip tech, and your rights under you gene.com/privacy-policy	
Step 7	Health Care Provide	r Certification			
the prescribing physic you are prescribing th of this medication for (as defined by the Hea the contracted dispen- continuing therapy, as reimbursement for fre above-named patient investigation (BI), bendabsence of a checkboo- taken until the patient	ian. (b) If the indication for an "una such a use. (c) I received alth Insurance Portability sing pharmacy, or other a break in treatment wo e product provided to the the prescription describer its re-verification, prior a selecting a service, we at consent document has	pr which you are prescripproved" use, meaning the authorization to releand Accountability Act contractors for the purpuld negatively impact the patient. I request General herein. (e) The servic authorization support (liwill perform BI/PA services been received. (g) Formation (g) Fo	bing a Genentech proceed that the FDA has not a case the information about 1996 [HIPAA]) to Genese of requesting reimple patient's therapeutic nentech Access Solutiones you are requesting of PA), co-pay card and concess on behalf of the part prescribers in states	nd the treatment decision has luct is not listed in the FDA-approved the efficacy, dosage a ove and other protected healt mentech, Inc., Genentech Accelbursement support, assisting is outcome and (d) I will not attens convey to the pharmacy choose behalf of the patient may incorpay assistance foundation refitient. (f) No action on these set with official prescription for along with this enrollment for	proved label, amount or safety h information ss Solutions, in initiating or empt to seek usen by the clude benefits ferral. In the ervices will be m requirements,
Sign, date & (877) 313-2	% fax to *Prescrib	er's Signature:(Orig	nal or stamped signatu	re required) *Date:	/ /

†National Provider Identifier.