Genentech
A Member of the Roche Group
Access Solutions

for Rituxan® & ACTEMRA®

(rituximab) (tocilizumab)

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Complete online by scanning QR code or visit
Quick Enroll (QE)

Required field (*) **M-US-00006696(v2.0)**

Step 1 Patient Information

***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 Patient's Therapy (check all that apply)

☐ **Rituxan® (rituximab)**

SIG: Infuse: _____ mg

☐ Day 1 and day 15
☐ Once a week for 4 weeks
☐ Other: _____
☐ Dispense Rituxan vials:
_____ 100-mg dose
_____ 375-mg dose
_____ 500-mg dose
Refill _____ times

☐ **ACTEMRA® (tocilizumab) intravenous (IV) infusion**

SIG: Infuse: _____ mg

☐ Once every 2 weeks
☐ Once every 4 weeks
☐ Other: _____
☐ Dispense ACTEMRA vials:
_____ 80-mg dose _____ 200-mg dose
_____ 400-mg dose
Patient weight: _____ lbs
Refill _____ times

☐ **ACTEMRA subcutaneous (SC) self-injectable**

☐ Prefilled syringe ☐ Autoinjector (ACTPen®)

Inject 162-mg

☐ Once a week ☐ Once every 2 weeks
☐ Other: _____
Dispense:
☐ 1 month ☐ 2 months ☐ 3 months
☐ Other: _____
Patient weight: _____ lbs
Refill _____ times

Step 4 Diagnosis and Clinical Information

To the highest level of specificity, provide:

***Primary diagnosis code:** _____ Anticipated date of treatment: ___ /___ /_____

Secondary diagnosis code: _____ Has the patient started therapy? ☐ Yes ☐ No

Step 5 Acquisition and Administration Information

Specialty pharmacy needed for Rituxan or ACTEMRA dispensing? ☐ Yes ☐ No (physician's office will supply)

Preferred specialty pharmacy: _____

Place of infusion: ☐ Prescribing physician's office ☐ Other physician's office ☐ Hospital outpatient ☐ Other: _____

Infusion site name: _____ Infusion site tax ID #: _____

Infusion site NPI† #: _____ Street: _____ Suite: _____

City: _____ State: _____ ZIP: _____

†National Provider Identifier.

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Step 6 Patient Information (please re-enter)

***First name:** _____ ***Last name:** _____ ***Date of birth (MM/DD/YYYY):** ___ /___ /_____

Step 7 Prescriber Information

***First name:** _____ ***Last name:** _____

***Practice name:** _____

***Street:** _____ Suite: _____ ***City:** _____

***State:** _____ ***ZIP:** _____ Prescriber tax ID #: _____

Prescriber NPI† #: _____ Group NPI† #: _____

Office contact: _____ 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 **www.gene.com/privacy-policy**.

Step 8 ACTEMRA and Rituxan Immunology Co-pay Program Enrollment Criteria

☐ **By checking this box, I certify that:**

- I have the patient's consent to enroll in the ACTEMRA® (tocilizumab) or Rituxan® (rituximab) Immunology Co-pay Program for assistance with drug out-of-pocket costs and/or Genentech ACTEMRA or Rituxan administration out-of-pocket costs
- The patient is not using and I 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 ACTEMRA or Rituxan 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 ACTEMRA and Rituxan Immunology 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: **RACopay.com/terms-and-conditions**

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.**

- If you are seeking support services for ACTEMRA subcutaneous, please continue by providing a prescriber signature below. Once signed and dated, fax pages 1 and 2 to (866) 681-3288
- Otherwise, no signature is needed. Please fax pages 1 and 2 to (866) 681-3288

Sign, date & fax to **(866) 681-3288**

***Prescriber's Signature:** _____ ***Date:** ___ /___ /_____
(Original or stamped signature required)

†National Provider Identifier.