Genentech | ACCESS SOLUTIONS
A Member of the Roche Group

for XOLAIR®
(omalizumab) for subcutaneous use

# Prescriber Service Form

***SUBMIT ONLY REQUESTED DOCUMENTS***

**Required field (*)** **M-US-00004706(v1.0) 12/20**

## 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: _____

Alternate contact name: _____ Relationship: _____ Alt. phone: (___) ___-_____

## Step 2 Insurance Information

Is the patient insured? ☐ Yes ☐ No Has patient started therapy? ☐ 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 health insurance cards.**

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

## Step 3 Diagnosis and Clinical Information

***Complete to the highest level of specificity for diagnosis codes:**

**ALLERGIC ASTHMA** ☐ J45.40 Moderate persistent asthma, uncomplicated ☐ J45.50 Severe persistent asthma, uncomplicated

**CHRONIC IDIOPATHIC URTICARIA** ☐ L50.1 Idiopathic urticaria

**NASAL POLYPS** ☐ J33.0 Polyp of the nasal cavity ☐ J33.1 Polypoid sinus degeneration
☐ J33.8 Other polyp of sinus ☐ J33.9 Nasal polyp, unspecified

**Other diagnosis code:** _____

## Step 4 Acquisition and Administration Information

Dispense XOLAIR: ☐ Prefilled Syringe or ☐ Vial Dispensing of XOLAIR through: ☐ Specialty pharmacy ☐ Buy and bill

Anticipated date of treatment: ___/___/_____ Preferred specialty pharmacy: _____

Place of administration: ☐ Physician's office ☐ Hospital-based outpatient department (HOPD) ☐ Alternate injection center

Ship to: ☐ Physician's office ☐ Hospital-based outpatient department (HOPD) ☐ Alternate injection center

Place of administration name: _____ Place of administration tax ID #: _____

Street: _____ Suite: _____ City: _____ State: _____ ZIP: _____

## Step 5 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: (___) ___-_____

## Step 6 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 card and co-pay assistance foundation referral. **(f) No action on these services will be taken until the patient consent document has been received.**

†National Provider Identifier.

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**This page is OPTIONAL unless you are requesting the XOLAIR Starter Program for your patient. Please fully complete all fields.**

## Step 7 Patient Information (please re-enter)

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

## Step 8 XOLAIR Starter Program (signature required)

For eligibility criteria, please speak to your XOLAIR representative.

**XOLAIR Starter Program prescription:** ☐ Dispense a free 28-day XOLAIR starter supply refill x2 subcutaneously

**ALLERGIC ASTHMA**

☐ Moderate to severe persistent allergic asthma ☐ History of positive skin or RAST test to a perennial aeroallergen

☐ Symptoms inadequately controlled with inhaled corticosteroids (ICS)

Pretreatment serum IgE level IU/mL (1.0 kU/L=1.0 IU/mL; 2.4 ng/mL=1.0 IU/mL): IgE level: _____ Patient weight: _____ kg

**CHRONIC IDIOPATHIC URTICARIA (CIU)**

☐ Patient has had CIU for 6 weeks or more

Other CIU therapies: ☐ H1 antihistamine ☐ Other: _____

**NASAL POLYPS**

☐ Patient has inadequate response to nasal corticosteroids

Pretreatment serum IgE level IU/mL (1.0 kU/L=1.0 IU/mL; 2.4 ng/mL=1.0 IU/mL): IgE level: _____ Patient weight: _____ kg

☐ **Other:** _____

## Step 9 Prescription Information

**Prescription type:** ☐ **Naïve/new start** ☐ **Restart** **Last injection date (if applicable):** ____/____/____

**Dispense XOLAIR:** ☐ Prefilled Syringe ☐ Vial

***Quantity dispensed:** ☐ 30-day supply ☐ 90-day supply Refill: _____ times

**Prescription:** (Please check dosage and frequency)

| FREQUENCY | Every 2 weeks | | | Every 4 weeks | | |
|---|---|---|---|---|---|---|
| MG/DOSE: | ☐ 225 | ☐ 300 | ☐ 375 | ☐ 75 | ☐ 150 | ☐ 225 |
| | ☐ 450 | ☐ 525 | ☐ 600 | ☐ 300 | ☐ 450 | ☐ 600 |

## Step 10 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 card and co-pay assistance foundation referral. **(f) No action on these services will be taken until the patient consent document has been received.**

Sign, date and fax to **(800) 704-6612**

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

# RESPIRATORY PATIENT CONSENT FORM

Genentech | ACCESS SOLUTIONS
A Member of the Roche Group

Genentech-Access.com
Phone: (866) 422-2377 Fax: (866) 480-7762
6 a.m.–5 p.m. (PT) M-F

M-US-00004739(v2.0) 08/20

Required field (*)

## Patient Information (to be completed by patient or their legally authorized person)

*First name: _____ *Last name: _____

Home phone†: (_____) _____ - _____ Cell phone†: (_____) _____ - _____

☐ OK to leave a detailed message? ☐ OK to send a text message? Date of birth (MM/DD/YYYY) ___/___/___

Email: _____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Alternate Contact (optional) Full name: _____

Relationship: _____ Phone†: (_____) _____ - _____

**1** Patient authorization via signature is required in order to obtain services from Genentech Access Solutions and the Genentech Patient Foundation. By signing this box, you agree to the terms in the 'About Your Consent' section.

REQUIRED

**Sign and date here**

_____ *Signature of Patient/Authorized Person (A parent or guardian must sign for patients under 18 years of age)

___/___/___ *Date signed (MM/DD/YYYY)

**Person signing (if not patient)**

_____ Print first name _____ Print last name _____ Relationship to patient

**2** Financial Eligibility Information: Complete for Genentech Patient Foundation **only**

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

**Sign and date here**

_____ **Signature of Patient/Authorized Person** (A parent or guardian must sign for patients under 18 years of age)

___/___/___ **Date signed** (MM/DD/YYYY)

**3** Patient consent to enroll in **optional** disease-specific education, support programs, market research and communications offered by Genentech USA, Inc., its partners, and their respective affiliates ("Sponsors") that may be considered marketing. I understand my PII may be needed by Sponsors for me to participate in these programs.

**Sign and date here to choose to enroll**

_____ **Signature of Patient/Authorized Person** (A parent or guardian must sign for patients under 18 years of age)

___/___/___ **Date signed** (MM/DD/YYYY)

†By providing my phone number and signing Box 3, I authorize Genentech USA, Inc., its partners, and their respective affiliates ("Sponsors") to use auto-dialers or prerecorded and artificial voice to contact me. I understand that these calls/texts may mention the name of Genentech or Sponsors' jointly-marketed products or services, details about my insurance coverage and my doctor's name. I understand that I am not required to consent to being contacted by phone or text message as a condition of enrollment or of the purchase of any Genentech or Sponsors' jointly-marketed products or services. Message and data rates may apply. I understand that I may opt out of receiving these communications at any time by calling (877) GENENTECH (877-436-3683).

**Once this page (3/3) has been completed,** please text a photo of the page to **(650) 877-1111,** or fax to **(866) 480-7762.** You can also complete this form online at **Genentech-Access.com/PatientConsent.**