STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays.

Phone: (866) 681-3261 **Fax:** (866) 681-3288 Genentech-Access.com/Rheumatology

Access Solutions®

SERVICES REQUESTED*
(check only those that apply)

☐ Benefits Investigation/ Prior Authorization ☐ Appeals Support ☐ Co-pay Assistance ☐ GATCF† Eligibility Screening ☐ GATCF Patient Assistance

PATIENT INFORMATION

Last name*: _____

First name*: _____

Birth date*: _____ Gender*: ☐ Male ☐ Female

Street: _____

City: _____ State*: _____ ZIP: _____

Home phone: _____

Work/cell phone: _____ Email: _____

Alternate contact: _____

Relationship to patient: _____

OK to contact patient for additional information? ☐ Yes ☐ No

INSURANCE INFORMATION

Does the patient have insurance? ☐ Yes ☐ No

Primary insurance name: _____

Phone: _____

Subscriber name: _____

Subscriber ID #: _____

Policy/group #: _____

Secondary insurance name: _____

Phone: _____

Subscriber name: _____

Subscriber ID #: _____

Policy/group #: _____

DIAGNOSIS/TREATMENT

DIAGNOSIS (highest level of specificity)*:

☐ Rheumatoid Arthritis (RA) (714.0)

☐ Granulomatosis with Polyangiitis (GPA) (446.4)

☐ Microscopic Polyangiitis (MPA) (446.0)

☐ Systemic Juvenile Idiopathic Arthritis (SJIA) - ICD-9-CM: _____

☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA) - ICD-9-CM: _____

☐ Other: Specify by ICD-9-CM: _____

Check one desired patient therapy*:

☐ Rituxan® (rituximab)

☐ ACTEMRA® (tocilizumab) IV infusion

☐ ACTEMRA SC self-injectable

Select one: ☐ DMARD-IR ☐ TNF-IR

Previous treatment(s) since diagnosis:

☐ Cimzia ☐ Enbrel ☐ Humira ☐ Methotrexate ☐ Orencia

☐ Remicade ☐ Simponi ☐ Xeljanz ☐ Other: _____

Has patient started prescribed therapy? ☐ Yes ☐ No

Next date of treatment: _____

Concurrent therapy prescribed with Rituxan or ACTEMRA: _____

INFUSION AND DRUG ACQUISITION INFORMATION

Specialty pharmacy needed for Rituxan or ACTEMRA dispensing?

☐ Yes ☐ No (MD'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: _____

City: _____ State: _____ ZIP: _____

Contact name: _____

Phone: _____

PRESCRIBER INFORMATION

Last name*: _____

First name*: _____

Practice name: _____

Specialty: _____

Street: _____

City: _____ State*: _____ ZIP: _____

Phone: _____ Fax: _____

Prescriber tax ID #: _____ Prescriber NPI #: _____

DEA #*: _____ Group NPI #: _____

State license #: _____ PTAN§: _____

Reimbursement/clinical contact name: _____

Reimbursement/clinical contact phone/fax: _____

SHIPPING FOR GATCF

Shipping location: ☐ Patient ☐ Practice ☐ Facility

Shipping address same as address listed in Patient or Prescriber sections of this form? ☐ Yes ☐ No If no, complete the remainder of this section.

Facility/practice or patient name: _____

DEA #: _____ License #: _____

Street (street address required, no PO boxes): _____

City: _____ State: _____ ZIP: _____

Contact name: _____

Phone: _____ Fax: _____

*Required field.
†Genentech® Access to Care Foundation.
‡National Provider Identifier.
§Provider Transaction Access Number.

PRESCRIPTION

For Rituxan® (rituximab) Patients Only

SIG: Infuse: _____ mg on ☐ Day 1 and Day 15 ☐ Other: _____
☐ Once a week for 4 weeks Refill _____times

☐ Dispense Rituxan vials: _____ 100-mg/dose _____ 500-mg/dose

For ACTEMRA® (tocilizumab) Patients Only

Intravenous (IV) Infusion

SIG: Infuse: _____ mg ☐ Once every 4 weeks ☐ Other: _____
☐ Once every 2 weeks Refill _____times

☐ Dispense ACTEMRA vials:
_____ 80-mg/dose _____ 200-mg/dose _____ 400-mg/dose

Subcutaneous self-injectable

Inject 162 mg

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

ACT Fast free starter supply only (ACTEMRA subcutaneous patients only)

Drug: ACTEMRA subcutaneous self-injectable 162 mg
Dispense: 15-day supply ☐ Once every week ☐ Once every 2 weeks
Patient weight: _____
Refill _____times

UNAPPROVED USE WARNING: Please read the FDA-approved labels for Rituxan and ACTEMRA before prescribing. If the indication for which you are prescribing Rituxan or ACTEMRA is not listed in the label, you are prescribing Rituxan or ACTEMRA for an "unapproved" use. The fact that the use for which you are prescribing Rituxan or ACTEMRA is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of Rituxan or ACTEMRA when used for such a use. Nevertheless, GATCF will consider providing Rituxan or ACTEMRA for your patient with this admonition, based upon your medical order, within program requirements.

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Genentech Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Genentech products, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided and (d) I appoint Genentech Access Solutions solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein.

I agree to comply with the program guidelines as established by Genentech, Inc. and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted. I further understand that Genentech will provide vial replacement in a configuration that will create the least amount of wastage.

Print patient's name here

Patient last name*: _____ First name*: _____ Birth date*: _____

Sign and date here

Prescriber's Signature* _____ Date* _____
(Original or stamped signature required.)

Complete this form online via My Patient Solutions™, our online patient management tool. Visit Genentech-Access.com/Rheumatology to register for My Patient Solutions.

*Required field.

STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays.

SERVICES REQUESTED

- Check the appropriate services requested. Genentech Access Solutions and/or GATCF cannot perform services without your specific authorization

INSURANCE INFORMATION

- If the patient is insured, provide a front and back copy of the patient's drug card

DIAGNOSIS/TREATMENT

- Check the appropriate Diagnosis Code
- If "Other" is checked, specify the ICD-9-CM code to the highest level of specificity
- By checking the appropriate box, indicate the previous treatment
- If "Other" is checked, identify the treatment(s)

INFUSION AND DRUG ACQUISITION INFORMATION

- Check the appropriate box to indicate the need for a specialty pharmacy to dispense Rituxan® (rituximab) or ACTEMRA® (tocilizumab). Genentech Access Solutions will verify with your patient's insurance plan whether a specialty pharmacy is in network
- Complete according to the planned (patient has not yet received Rituxan or ACTEMRA) or administered (patient has already been infused with Rituxan or ACTEMRA) dosing

PRESCRIPTION

Please indicate the prescribed therapy (Rituxan or ACTEMRA)

- Complete the dose and refill fields only if you are planning to use a specialty pharmacy to acquire Rituxan or ACTEMRA for your patient, or if you are requesting GATCF assistance for your patient
- If you will not infuse the patient in your office and need assistance with locating an infusion site, Genentech Access Solutions will verify with your patient's insurance plan the infusion sites that are in network

PRESCRIBER INFORMATION

- This form cannot be processed without an original or stamped signature

ATTACH TO COMPLETED SMN

- Attach a signed and dated Patient Authorization and Notice of Release of Information (PAN) form. Genentech Access Solutions and/or GATCF cannot work with the insurance plan on your patient's behalf without a signed and dated PAN form
- Providing additional documents or information with this form, other than what is requested, will delay processing

REMINDER: This form cannot be processed without a prescriber's signature and date, as well as a signed and dated PAN form.

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