Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – Patient-Administered Drugs

Phone (866) 681-3329 - Fax (866) 681-3338

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed **ACTEMRA® (tocilizumab)** therapy. Complete this form when the outcome for any situations listed below has been met.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

- ❑ My office received an initial claim denial or Prior Authorization (PA) denial.
  Date of initial claim denial or PA denial: ____/____/____
  Reason for denial:_____
- ❑ My office has submitted for a first-level appeal.
  Date appeal letter submitted:__/____/____
- ❑ My office received a first-level appeal denial.
  Date of appeal denial letter:____/____/____
  Reason for denial:_____
- ❑ My office received a peer-to-peer denial.
  Date of review:_/____/____
  Reason for denial:_____
- ❑ My patient has met the daily/yearly CAP for insurance coverage.
  Date CAP was met:____/____/____
  Date CAP reset:____/____/____

PLEASE NOTE: *If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.*

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required)*: _____Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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