Rheumatology Statement of Medical Necessity (SMN)

PLEASE DO NOT SEND ANY ADDITIONAL DOCUMENTATION.

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Genentech-Access.com/Rheumatology

Phone: (866) 681-3261 **Fax:** (866) 681-3288

Required field (*) **ACS/062315/0105(1)** **10/16**

Services requested* (check only those that apply)

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

Step 1: Patient Information

Last name*: _____ **First name***: _____ **DOB***: ____ /____ /____ Gender: ☐ M ☐ F

Street: _____ City: _____ **State***: ____ ZIP: _____

Home phone: (____) _____ - _____ Work/cell: (____) _____ - _____ Patient preferred language (if other than English): _____

OK to contact patient for missing information to perform service(s) requested? ☐ Yes ☐ No

Alternate contact name: _____ Relationship: _____ Alternate phone: (____) ____ - _____

Step 2: Insurance Information

☐ **No Insurance**

Primary insurance name: _____

Phone: (____) _____ - _____ Subscriber name: _____

Subscriber ID #: _____

Policy/group #: _____

Secondary insurance name: _____

Phone: (____) _____ - _____ Subscriber name: _____

Subscriber ID #: _____

Policy/group #: _____

Step 3: Treatment/Diagnosis

Check one desired patient therapy*:

☐ Rituxan® (rituximab) ☐ ACTEMRA® (tocilizumab) IV infusion

☐ ACTEMRA SC self-injectable

Primary diagnosis code*: _____

Secondary diagnosis code: _____

☐ Prior inadequate response to TNF

Has patient started prescribed therapy? ☐ Yes ☐ No

Next date of treatment: ____/____ /____

☐ Concurrent methotrexate prescribed with Rituxan or ACTEMRA

Step 4: Prescriber Information

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

Specialty: _____ **Street***: _____ Suite #: _____

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

Prescriber NPI‡ #: _____ Group NPI #: _____ PTAN§: _____

Office contact: _____ Office contact phone: (____) _____ - _____ Fax: (____) _____ - _____

Step 5: 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: _____ Suite #: _____

City: _____ State: _____ ZIP: _____

Contact name: _____ Phone: (____) _____ - _____

Ship to: ☐ Patient ☐ Prescribing physician's office ☐ Infusion site listed above

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

Print patient's name here Patient last name*: _____ First name*: _____ DOB*: _____ /_____ /_____

Step 6: Prescription Information

For Rituxan® (rituximab) Patients Only

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

☐ Dispense Rituxan vials: _____ 100-mg dose _____ 500-mg dose Refill _____ times

For ACTEMRA® (tocilizumab) Patients Only

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 Refill _____ times

Subcutaneous self-injectable

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 7: Starter Prescription

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: _____ lbs Refill _____ times

Step 8: Sign and Date Form

PHYSICIAN CERTIFICATION: By signing below, I certify: (a) the above therapy is medically necessary, (b) I 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 and/or the evaluation of the patient's eligibility for GATCF, as a break in treatment would negatively impact the patient's therapeutic outcome and (c) I will not attempt to seek reimbursement for free product provided to the patient. I request Genentech Access Solutions convey to the pharmacy chosen by the above-named patient the prescription described herein.

I agree to comply with the Genentech, Inc. program guidelines and understand that GATCF, at its sole 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 wastage. If applying for GATCF, I certify that (a) this patient has no medical insurance coverage or otherwise meets the financial criteria for the prescribed therapy, and is not eligible for other product financial support programs, and (b) the therapy identified above will not be used in a clinical trial. Note: Prescribers in all states must follow applicable law for a valid prescription and who is considered an authorized prescriber. For prescribers in states with official prescription form requirements, such as New York, please submit prescriptions on an official state prescription blank along with this form.

Unapproved Use Warning: Please read the FDA-approved label for Genentech products before prescribing. If the indication for which you are prescribing a Genentech product is not listed in the FDA-approved label, you are prescribing the medication for an "unapproved" use, meaning that the FDA has not approved the efficacy, dosage amount or safety of this medication when used for such a use. Nevertheless, GATCF will consider providing the medication for your patient with this admonition, based upon your medical order, within program requirements.

Sign and date here, then fax to (866) 681-3288

Prescriber's Signature*: _____ **Date*:** _____ /_____ /_____

(Original signature required. This form cannot be processed without an original signature.)

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STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays. Complete this form online via My Patient Solutions™, our online patient management tool.

Visit Genentech-Access.com/Rheumatology to register for My Patient Solutions.

SERVICES REQUESTED

- Check the appropriate services requested on behalf of the patient. Genentech Access Solutions and/or GATCF cannot perform services without your specific request

TREATMENT/DIAGNOSIS

- Enter the Diagnosis Code to the highest level of specificity

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 health 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
- Check the appropriate box to indicate the desired infusion location

PRESCRIPTION INFORMATION

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 health insurance plan the infusion sites that are in network

PRESCRIBER SIGNATURE

- Requests for appeals support and GATCF patient assistance 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.

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