Phone: (805) 719-3700
Fax: (805) 413- 9099
Website: infusionforhealth.com

OCREVUS INFUSION ORDER – MAINTENANCE DOSE

Please fax a copy of patient's:

- □ **Demos**
- □ **Current Lab Results**
- □ **Medication List**
- □ **MRI**
- □ **Copy of Insurance Cards**
- □ **Hep B Labs**
- □ **Recent Office Notes**
- □ **McDonald Criteria for MS**

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD-10: _____

PRE-MEDICATIONS:	**Diphenhydramine**	**50 mg**	**IV/PO**
(30 mins before infusion)	**Solu-Medrol**	**125 mg**	**IV**
	Acetaminophen	**1000 mg**	**PO**

PRN (infusion reactions):	**Diphenhydramine**	**25 mg/50 mg**	**IV/PO**
	Zyrtec	**10 mg**	**PO**
	Acetaminophen	**650 mg**	**PO**
	Solu-Medrol	**125 mg**	**IV**
	Normal saline bolus	**500 mL**	**IV**

Ocrevus (ocrelizumab) IV Maintenance Dosage:

☐ **600 mg in 500 mL 0.9% Sodium Chloride 6 months after loading dose, then every 6 months**

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office Phone Number: _____ Office Fax:_____

Office Address: _____Contact Person: _____

Please fax this order including Access Solutions Forms to (805) 413-9099

Genentech | ACCESS SOLUTIONS®
A Member of the Roche Group
for OCREVUS®
(ocrelizumab)

OCREVUS Start Form

Instructions for Patients

By completing this form you can:

Learn about your health insurance coverage and other options to get your Genentech medicine

Enroll into optional disease-specific education, patient support services and communication

We can start assisting you once this form is sent back to us by you or your health care provider on your behalf.

You can choose not to sign this form. However, please note that we cannot assist you without your signed authorization.

To obtain assistance, please follow these steps:

1. **Read the Patient Authorization Information** describing Genentech patient support services on pages 2 and 3.
2. If you wish to enroll in OCREVUS Access Solutions, please **fill in SECTION 1** and **sign and date SECTION 1A** on page 4.
3. If you wish to enroll in additional educational and marketing programs, please **sign and date SECTION 1B** on page 4.
4. If you wish to determine if you are eligible for Genentech Patient Foundation, please **complete SECTION 1C** on page 4.
5. Your health care provider will fill out page 5 of the Start Form and send the form back to us.

Be sure to fill in all information, complete all required fields (*) and sign and date the form or it could delay our ability to help you.

Instructions for Health Care Providers

Please write legibly and complete all required fields (*) on the OCREVUS Start Form to prevent delays.

By completing this form, you are requesting services on behalf of your patient, which may include:

- Benefits investigation
- Benefits reverification approximately 6 weeks prior to patient's next treatment date
- Infusion site identification
- Assistance with the prior authorization process and appeals resources
- Referral to co-pay support options or Genentech Patient Foundation services (please check the appropriate boxes on behalf of your patient)

To enroll your patient, please follow these steps:

1. **Have your patient read the Patient Authorization Information** describing Genentech patient support services on pages 2 and 3.
2. Have your patient read, **sign and date SECTION 1A** on page 4. Your patient should **sign and date SECTIONS 1B and 1C** on page 4 if they would like to request additional services listed on page 3.
3. **Complete page 5.** If requesting assistance from Genentech Patient Foundation, sign and date the Physician Certification.

Diagnosis Code and Clinical Information: Enter the diagnosis code to the highest level of specificity.

Helpful Terminology

Genentech: The maker of the medicine your provider wants to prescribe. Genentech is committed to helping patients get the medicine their provider prescribed.

Genentech Access Solutions: A team at Genentech that works with your doctor and health insurance plan to help you get your medicine.

Genentech Patient Foundation: A program that gives free Genentech medicine to people who don't have insurance coverage or who have financial concerns and meet certain eligibility criteria.

Household size: Number of people living in your household, including you.

Net household income: How much you and the members of your household make each year minus specific deductions. This is also frequently referred to as your Adjusted Gross Income or AGI. This information is needed to determine Genentech Patient Foundation eligibility.

Education and patient support services: Optional programs offered by Genentech to help you start and stay on your medicine. Services may vary based on your medical condition and could include co-pay assistance, clinical support, marketing communication and general disease information.

Deductible: The amount you pay for health care services or medicines out of pocket before your health insurance plan begins to pay.

Out-of-pocket costs: The amount not paid by the insurance plan that you must pay for your treatment. This includes deductibles, co-pays and co-insurance.

Co-pay assistance: Programs available to help eligible patients pay for their medicines.

Alternate contact: Someone you choose to be your contact person if Genentech Access Solutions cannot reach you.

Personally identifiable information (PII): Any information that can be used to find out who you are. This might include your name, birthdate, address or telephone number.

If I receive free Genentech medicine from the Genentech Patient Foundation:

- I will not sell or give out this medicine since it is unlawful to do so. I am responsible to make sure these medicines are sent to a secure address when shipped to me, and I must control any Genentech medicine that I receive
- I understand that, for purposes of an audit, the Genentech Patient Foundation could ask me for a copy of my IRS 1040 form or other proof of income

About Your Consent

Your personally identifiable information (PII) may include:

- Name and birthdate
- Address, telephone number and email address
- Important financial information, as necessary
- Information on your medical condition, as necessary
- Information about your health benefits or health insurance coverage

Who May See and Use My PII

I authorize Genentech and/or Genentech Patient Foundation to (i) use my PII for the purpose of facilitating my access to Genentech products and providing the services described below, and (ii) further disclose my PII to others who are assisting them in these services, and to my health care provider(s), health care entities, pharmacies, and health plan(s) for purposes of providing these services.

Reasons for sharing and using my information may include:

- Working with my health care plan to understand coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility and enrollment into financial assistance services, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office
- Providing treatment reminders and education

I direct and authorize my physician, pharmacy and my health plan(s) to disclose my PII to Genentech and its partners, as necessary for Genentech to provide the above services.

Once I sign this Patient Consent Form and my PII is transmitted to Genentech and/or Genentech Patient Foundation, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect or prohibit the redisclosure of the PII disclosed to Genentech and/or Genentech Patient Foundation by my health care provider or others covered by the HIPAA laws. I understand that Genentech and Genentech Patient Foundation are committed to protecting my information and keeping it secure and confidential while it is being collected or used to assist me and that the use and disclosure of my information will be limited to that described above. I can choose not to sign this form, but Genentech and Genentech Patient Foundation will not be able to assist me without it. However, my health care providers and health insurer may not condition either my treatment or my payment, enrollment or eligibility for benefits on signing this form.

The length and terms of this form

- This form is valid for 3 years from the date I signed or the date I last enrolled, whichever comes first, unless a shorter period is required by law
- I agree that if I reside in the state of Maryland, this form will be valid for no longer than 1 year from the date I signed
- I have the right to cancel this authorization. If I cancel, this means that Genentech and/or the Genentech Patient Foundation will no longer use or share my PII, but this will not apply to PII already used or shared or when it is required by law. To cancel, I must send a written notice to Genentech. It can be sent by fax or by mail to the address below. If I cancel, I know that Genentech and the Genentech Patient Foundation will no longer be able to assist me with access to my Genentech products. The address is Genentech, 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990

I understand that I, as the patient or signer, have a right to receive a copy of this signed form over the time it is valid.

Patient Consent Form – to be filled out by patient

*Required field
‡Required if not the patient

SECTION 1: Patient Information

_____
First name*

_____
Last name*

_____ /_____ /_____
Date of birth* (MM/DD/YYYY)

Preferred form of communication (check all that apply)

☐ Email: _____

☐ Home phone†: (____) ____ - _____

☐ Cell phone†: (____) ____ - _____

A detailed message can be left to all numbers provided and/or all authorized individuals.

OK to leave detailed voice message?
○ Yes ○ No

OK to send a text message?
○ Yes ○ No

Best time to reach me:
☐ Morning ☐ Afternoon

_____
Patient preferred language

_____
Alternate contact name

_____
Relationship to Patient

(_____) _____ - _____
Phone

_____
Email

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

Sign and date here

_____ _____ / _____ / _____
Signature of Patient/Authorized Person* **Date signed***

_____ _____
Print first name‡ Print last name‡

_____
Relationship to Patient (required if not the patient)

1B: Patient consent to enroll in **optional** disease-specific education, support programs, market research and communication that may be considered marketing. I understand my PII may be needed for me to participate in these programs.

Choose to enroll by signing and dating here

_____ _____ / _____ / _____
Signature of Patient/Authorized Person Date signed

†By providing my phone number and signing Section 1B, I authorize Genentech to use auto-dialers, prerecorded messages and artificial voice messages to contact me. I understand that these calls/texts may mention the name of Genentech 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 any purchase of Genentech products or enrollment.

1C: 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 2.

Household size (including you): _____

Annual net household income:

○ Under $75,000
○ $75,000 – $100,000
○ $100,001 – $125,000
○ $125,001 – $150,000
○ Over $150,000

Choose to enroll by signing and dating here

_____ _____ / _____ / _____
Signature of Patient/Authorized Person Date signed

(Required if requesting assistance from the Genentech Patient Foundation)

Genentech | ACCESS SOLUTIONS
A Member of the Roche Group
for OCREVUS®
(ocrelizumab)

OCREVUS Start Form

Prescriber Service Form – to be filled out by health care provider

*Required field

SECTION 2: Patient Information ☐ DO NOT CONTACT PATIENT

First name* _____ Last name* _____

Date of birth* (MM/DD/YYYY) ____/____/____ **Gender:** O Male O Female

Street _____ City _____

State* _____ ZIP _____ Phone* (____) _____-_____

SECTION 3: Insurance Information ☐ NO INSURANCE

If insured, please fill out information below **or** attach a copy of the patient's insurance card(s) and skip to section 4. ☐ COPY OF INSURANCE CARD ATTACHED

☐ PA IN PLACE (AUTH #): _____

Primary insurance name _____ Phone (____) _____-_____

Subscriber name _____

Subscriber/Policy ID # _____

Group # _____

Secondary insurance name _____ Phone (____) _____-_____

Subscriber name _____

Subscriber/Policy ID # _____

Group # _____

SECTION 4: Prescriber Information

First name* _____ Last name* _____

Practice name* _____

Street* _____ Suite # _____

City* _____ State* _____ ZIP* _____

Prescriber tax ID # _____ Prescriber NPI§ # _____

Group NPI§ # _____ Office contact name _____

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

SECTION 5: Infusion Site Location

O **Yes, please provide assistance locating an infusion site.** Please coordinate directly with:
O Health Care Provider O Patient

O **No, assistance is not needed.** Patient will be infused at:
O Prescriber's office (SECTION 4) O Preferred infusion site (please list below)

PREFERRED INFUSION SITE INFORMATION

INFUSION FOR HEALTH
Preferred infusion site name

Wendy M.
Infusion site contact name

464870667 Infusion site tax ID #
15082662213 Infusion site NPI§ #

77 ROLLING OAKS DR Street
201 Suite #

THOUSAND OAKS City
CA State
91361 ZIP

(805) 719-3700 Phone
(805) 413-9099 Fax

SECTION 6: Acquisition/Fulfillment of Drug

O Buy and Bill

O Specialty Pharmacy (SP) Preferred SP: _____

O Please conduct benefits investigation to determine procurement method

SECTION 7: Diagnosis Code and Clinical Information

Diagnosis code*: O G35 Multiple Sclerosis (MS)
O Relapsing Forms of MS (RMS)
◉ Primary Progressive MS (PPMS)

O Other diagnosis code: _____

Current/most recent MS therapy: _____

Has the patient started prescribed OCREVUS® (ocrelizumab)? ◉ Yes O No

If Yes: Patient's last date of treatment: ____/____/____

Anticipated date of next treatment: ____/____/____

SECTION 8: OCREVUS Prescription

O **Drug Allergies:** _____ O **None**

Other Medications: _____

Initial Dose:

☐ Initial dose SIG: Dispense (1) 300-mg vial Refills: 1

Instructions: Infususe 300mg day 1 and 300mg day 15

Subsequent Dose:

☑ Subsequent dose SIG: Dispense (2) 300-mg vials Refills: 1

Instructions: Infuse 600mg every 6 months

BY COMPLETING THIS FORM: I am requesting services on behalf of the patient, which may include benefits investigation and reverification, help navigating the prior authorization process and appeals support.

By signing 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 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 for such a use. (c) 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, as a break in treatment would negatively impact the patient's therapeutic outcome and (d) 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. (e) The services you are requesting on behalf of the patient, may include benefits investigation (BI), prior authorization support (PA), 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. (g) For prescribers in states with official prescription form requirements, such as New York, prescriptions must be submitted on an official state prescription pad along with this enrollment form.**

Sign and date here

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

(Original signature required for Genentech Patient Foundation support only. No signature required for other services.)

§National Provider Identifier.