Genentech | ACCESS SOLUTIONS®
A Member of the Roche Group

for LUCENTIS®
(ranibizumab injection)

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **M-US-00006694(v1.0)** **08/20**

Services Requested (Check all that apply) ☐ **Benefits Investigation/Prior Authorization** ☐ **Refer Patient to Co-pay Assistance** ☐ **Appeals Support**

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

Preferred language: ☐ English ☐ Spanish ☐ Other: ____________ Has patient started therapy? ☐ Yes ☐ No

Step 2 Insurance Information

Is the patient insured? ☐ 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 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

Please provide the appropriate diagnosis code(s) to the highest level of specificity. For ICD-10-CM coding information, please visit Genentech-Access.com/LUCENTIS.

Anticipated date of treatment: ____/____/____ ***Primary diagnosis code:** ____________

Secondary diagnosis code: ____________ Tertiary diagnosis code: ____________

Step 4 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 5 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. In the absence of a checkbox selecting a service, Genentech Access Solutions will perform BI/PA services on behalf of the patient. **(f) No action on these services will be taken until the patient consent document has been received.**

†National Provider Identifier.

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