Genentech
A Member of the Roche Group | Access Solutions

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **M-US-00006694(v3.0)**

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

Alternate contact name: _____ Relationship: _____ Alt. phone: (___) ___-____

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 Patient's Therapy (Check all that apply)

☐ **LUCENTIS® (ranibizumab injection)** | ☐ **SUSVIMO™ (ranibizumab injection)** ☐ Initial Fill and Implant Procedure ☐ Refill Exchange Procedure | ☐ **VABYSMO™ (faricimab-svoa)**

Step 4 Diagnosis and Clinical Information

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

Anticipated date of treatment: ____/____/____ ***Diagnosis code(s):** _____

Step 5 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 6 Administration Information (Complete for SUSVIMO™ only)

☐ Ambulatory Surgical Center ☐ Hospital Outpatient Department

Place of administration name: _____ Tax ID #: _____

Street: _____ Suite: _____ City: _____

State: _____ ZIP: _____ NPI† #: _____

Step 7 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.