

Step 1 Patient Information

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

*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
 Email: _____ Preferred language: English Spanish Other: _____

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.

Is prior authorization in place? Yes No Auth #: _____

| | Primary Insurance | Secondary Insurance | Pharmacy Benefit |
|----------------------------------|-------------------|---------------------|------------------|
| Insurance name | | | |
| Subscriber name (if not patient) | | | |
| Subscriber/Policy ID # | | | |
| Group # | | | |
| Insurance phone | | | |

Step 3 Diagnosis and Clinical Information

To the highest level of specificity, provide:

*Primary diagnosis code: _____ Has patient started therapy? Yes No
 Secondary diagnosis code: _____ *Metastatic basal cell carcinoma? Yes No
 *Locally advanced basal cell carcinoma recurred following surgery, or not a candidate for surgery, and not a candidate for radiation? Yes No

Erivedge[®] (vismodegib) capsule 150 mg
 150 mg daily Other: _____ Dispense: _____ -month supply Refill _____ times


Pharmacy and Shipping Information:
 Specialty pharmacy: Yes No Preferred specialty pharmacy: _____
 Onsite pharmacy: Yes No Onsite pharmacy: _____
 Ship to: Patient Practice Other: _____

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.

 Sign, date & fax to (877) 313-2659 *Prescriber's Signature: _____ *Date: ____ / ____ / ____
 (Original or stamped signature required)

[†]National Provider Identifier.