Genentech | ACCESS SOLUTIONS
A Member of the Roche Group

for Rituxan® (rituximab) & ACTEMRA® (tocilizumab)

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **ACS/010319/0002** **02/19**

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

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 Patient's Therapy (check all that apply)

☐ **Rituxan® (rituximab)**

SIG: Infuse: _____ mg

☐ Day 1 and day 15

☐ Once a week for 4 weeks

☐ Other: _____

☐ Dispense Rituxan vials:

_____ 100-mg dose

_____ 375-mg dose

_____ 500-mg dose

Refill _____ times

☐ **ACTEMRA® (tocilizumab) 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

Patient weight: _____ lbs Refill _____ times

☐ **ACTEMRA subcutaneous (SC) self-injectable**

☐ Prefilled syringe ☐ Autoinjector (ACTPen®)

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 4 Diagnosis and Clinical Information

To the highest level of specificity, provide:

***Primary diagnosis code:** _____

Secondary diagnosis code: _____

Anticipated date of treatment: ____/____/____

Has the patient started therapy? ☐ Yes ☐ No

Please **continue to Step 5** on the next page.

Genentech | ACCESS SOLUTIONS
A Member of the Roche Group

Prescriber Service Form

for Rituxan® (rituximab) & ACTEMRA® (tocilizumab)

SUBMIT ONLY REQUESTED DOCUMENTS

Required field (*) **ACS/010319/0002** **02/19**

Step 5 Patient Information (please re-enter)

***First name:** _____ ***Last name:** _____ ***Date of birth (MM/DD/YYYY):** ____/____/____

Step 6 Acquisition and Administration Information

Specialty pharmacy needed for Rituxan® (rituximab) or ACTEMRA® (tocilizumab) dispensing? ☐ Yes ☐ No (physician's office will supply)

Preferred specialty pharmacy: PYRAMIDS SP PHARMACY ph: 832-284-4933 fax: 888-383-2140

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: _____

Step 7 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 8 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. **(f) No action on these services will be taken until the patient consent document has been received.**

- If you are seeking support services for starter therapy or ACTEMRA subcutaneous, please continue by completing the step below and providing a prescriber signature. Once signed and dated, fax pages 1 and 2 to (866) 681-3288
- Otherwise, no signature is needed. Please fax pages 1 and 2 to (866) 681-3288

Step 9 Starter Request

ACT Fast free starter supply only (ACTEMRA subcutaneous patients only)

Drug: ACTEMRA subcutaneous self-injectable 162-mg

☐ Prefilled Syringe ☐ Autoinjector (ACTPen®)

Dispense: 15-day supply ☐ Once every week ☐ Once every 2 weeks Patient weight: _____ lbs Refill _____ times

Sign, date & fax to **(866) 681-3288**

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

(Original or stamped signature required)

†National Provider Identifier.