



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: _____
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.

Table with 2 main columns: Primary Insurance and Secondary Insurance. Rows include Insurance name, Subscriber name (if not patient), Subscriber/Policy ID #, Group #, and Insurance phone.

Step 3 Prescription Information

Table for Prescription Information with columns: Patient weight, Please specify quantity of each applicable vial, Directions, and Refills. Rows for Initial dose and Subsequent dose.

Preferred specialty pharmacy: _____ Onsite pharmacy: _____

Step 4 Diagnosis and Clinical Information (*Complete to the highest level of specificity for diagnosis codes.)

*Primary diagnosis code: _____ Does your patient have Hemophilia A With inhibitors? or Without inhibitors?
Has the patient started prescribed HEMLIBRA® (emicizumab-kxwh)? Yes No
Has it been 12 months or more since the patient's last HEMLIBRA injection? Yes No

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: (____) _____ - _____

If you are a resident of a US state that provides certain rights with respect to your personal information, a complete description of the personal information we may collect and process, the purposes for which it is used by Genentech, and your rights under your state's privacy laws concerning your personal information can be found in our privacy notice at www.gene.com/privacy-policy.

Step 6 HEMLIBRA Co-pay Assistance Program Enrollment

- By checking this box, I certify that:
• I have the patient's consent to enroll in the Genentech HEMLIBRA Co-pay Assistance Program for assistance with drug out-of-pocket costs and/or Genentech HEMLIBRA administration out-of-pocket costs
• The patient is not using and I will not bill any federal or state-funded health care program. This includes, but is not limited to, Medicare, Medicaid, Medigap, VA, DoD and TRICARE
• The patient is not currently receiving Genentech HEMLIBRA from the Genentech Patient Foundation
• The patient is not currently receiving assistance from any other charitable organization for any of their out-of-pocket costs that are covered by the Genentech HEMLIBRA Co-pay Assistance Program
• Genentech reserves the right to rescind, revoke or amend the program without notice at any time
• I have read and accepted the full Program Terms and Conditions as found on the following link: www.hemlibracopay.com/terms-and-conditions

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 program referral or enrollment and co-pay assistance foundation referral. (f) No action on these services will be taken until the patient consent document has been received.

Sign, date & fax to (877) 886-5629
*Prescriber's Signature: _____ (Original or stamped signature required) *Date: ____/____/____