Statement of Medical Necessity (SMN)

PLEASE DO NOT SEND ANY ADDITIONAL DOCUMENTATION.

Phone: (800) 530-3083 **Fax:** (877) 428-2326 Activase.com, Cathflo.com, and TNKase.com

Required field(*) ACS/062315/0109(3) 03/18

By completing this form, I am requesting GATCF† patient assistance on behalf of my patient.

Step 1: Patient Information

Last name*: _____ **First name*:** _____ **Birth date*:** _____ Gender: ☐ Male ☐ Female

Street*: _____ **City*:** _____ **State*:** _____ **ZIP*:** _____

Home phone: (_____) _____ Work/cell phone: (_____) _____ Email: _____

Alternate contact name: _____ Phone: (_____) _____

Relationship to patient: _____ OK to contact patient? ☐ Yes ☐ No Patient preferred language (if other than English): _____

Step 2: Insurance Information

Is patient currently insured? ☐ Yes ☐ No Has treatment been denied? ☐ Yes ☐ No

Is patient eligible for Medicaid? ☐ Yes ☐ No ☐ Pending If pending, date application submitted:____/____/____

Primary insurance name: _____ Phone: _____ Subscriber name: _____

Subscriber/Policy ID#: _____ Group: _____

Secondary insurance name: _____ Phone: _____ Subscriber name: _____

Subscriber/Policy ID#: _____ Group: _____

Step 3: Prescriber Information

Last name*: _____ **First name***: _____ **Practice name***: _____

Street*: _____ Suite #: _____ **City***: _____ **State***: _____ **ZIP***: _____

Prescriber tax ID #: _____ Prescriber NPI‡ #: _____ Group NPI #: _____

Office contact: _____ Office contact phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Step 4: Diagnosis Code and Clinical Information

Diagnosis code (highest level of specificity)*: Primary diagnosis code: _____ Other diagnosis code: _____

INFUSION AND DRUG ACQUISITION INFORMATION

Place of administration*: ☐ Physician's office ☐ Hospital outpatient ☐ Hospital inpatient ☐ Other: _____

Ship to: ☐ Prescribing physician's office ☐ Other address (indicated below): _____

Facility name: _____ Facility tax ID #: _____ Facility NPI #: _____

Street: _____ Suite #: _____ City: _____ State: _____ ZIP: _____

Please attach a completed Genentech® Access to Care Foundation (GATCF) Confirmation of Infusion/Injection when faxing form.

Indicate patient's therapy:

Activase® (alteplase)
☐ 100-mg quantity (vials): _____
☐ 50-mg quantity (vials): _____
Date of treatment: _____

Cathflo® Activase
☐ 2-mg quantity (vials): _____
Date of treatment: _____

TNKase® (tenecteplase)
☐ 50-mg kit: _____
Date of treatment: _____

Step 5: Sign and Date

PHYSICIAN CERTIFICATION: By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of requesting reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Genentech products, as a break in treatment would negatively impact the patient's therapeutic outcome and (c) I will not attempt to seek reimbursement for free product provided to the patient. I request Genentech Access Solutions convey to the pharmacy chosen by the above-named patient the prescription described herein.

I agree to comply with the program guidelines as established by Genentech, Inc. and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted. I further understand that Genentech will provide vial replacement in a configuration that will create the least amount of wastage. If applying for GATCF, I certify that (a) this patient has no medical insurance coverage or otherwise meets the financial criteria for the pharmaceutical identified above, and is not eligible for copay assistance or public health insurance programs, and (b) the pharmaceutical identified above will not be used in a clinical trial.

Special Note: Prescribers in all states must follow applicable law for a valid prescription. For prescribers in states with official prescription form requirements, such as New York, please submit prescriptions on an official state prescription blank along with this form.

Unapproved Use Warning: Please read the FDA-approved label for Activase, Cathflo Activase or TNKase before prescribing. If the indication for which you are prescribing Activase, Cathflo Activase or TNKase is not listed in the label, you are prescribing the medication for an "unapproved" use. The fact that the use for which you are prescribing this medication is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of this medication when used for such a use. Nevertheless, the Genentech® Access to Care Foundation (GATCF) will consider providing the medication for your patient with this admonition, based upon your medical order, within program requirements.

Sign and date here.

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

(Original signature required. This form cannot be processed without a prescriber's signature.)

*Required field. †Genentech® Access to Care Foundation. ‡National Provider Identifier.

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PLEASE DO NOT SEND ANY ADDITIONAL DOCUMENTATION.

Please write legibly and complete all required fields (*) to prevent delays.

GENENTECH® ACCESS TO CARE FOUNDATION

- The Genentech Access to Care Foundation (GATCF) helps eligible patients who meet specific criteria receive medicine free of charge

INSURANCE INFORMATION

- This section should include primary, secondary and pharmacy benefit insurance to ensure that ALL potential coverage can be explored, including Medicare and Medicaid if eligible

DIAGNOSIS CODE AND CLINICAL INFORMATION

- Enter the Diagnosis Code to the highest level of specificity

SHIPPING INFORMATION

- If the vials or kit should be shipped to a different facility or practice from the one listed in the Prescriber section, indicate that address, facility tax ID number and facility NPI number here
- Complete the primary contact information on the form

PRESCRIPTION INFORMATION

- Complete the dose field along with the dispense instructions

GATCF REQUIRED FIELDS

- All required fields are indicated with an asterisk (*)
- GATCF cannot process your SMN unless these fields are completed

ATTACH TO COMPLETED SMN

- Attach a signed and dated Patient Authorization and Notice of Request for Transmission of Health Information to Genentech Access Solutions and Genentech® Access to Care Foundation (PAN) form. GATCF cannot work on your patient's behalf without a signed and dated PAN form
- Include infusion/injection records

PROVIDING ADDITIONAL DOCUMENTS OR INFORMATION WITH THIS FORM, OTHER THAN WHAT IS REQUESTED, WILL DELAY PROCESSING.

REMINDER: This form cannot be processed without a signed and dated PAN form.

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