



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)

<p>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</p>	<p>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</p>	<p>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</p>
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Step 4 Diagnosis and Clinical Information

To the highest level of specificity, provide:
 *Primary diagnosis code: _____ Anticipated date of treatment: ____/____/____
 Secondary diagnosis code: _____ Has the patient started therapy? Yes No

Step 5 Acquisition and Administration Information

Specialty pharmacy needed for Rituxan or ACTEMRA dispensing? Yes No (physician's office will supply)
 Preferred specialty pharmacy: _____
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 6 Patient Information (please re-enter)

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

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: (_____) _____ - _____

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 8 ACTEMRA and Rituxan Immunology Co-pay Program Enrollment Criteria

By checking this box, I certify that:

- I have the patient's consent to enroll in the ACTEMRA® (tocilizumab) or Rituxan® (rituximab) Immunology Co-pay Program for assistance with drug out-of-pocket costs and/or Genentech ACTEMRA or Rituxan 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 ACTEMRA or Rituxan drugs 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 ACTEMRA and Rituxan Immunology Co-pay 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: RACopay.com/terms-and-conditions

Step 9 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.**



- If you are seeking support services for ACTEMRA subcutaneous, please continue by providing a prescriber signature below. 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

Sign, date & fax to (866) 681-3288 *Prescriber's Signature: _____ *Date: ____ / ____ / ____
 (Original or stamped signature required)

[†]National Provider Identifier.

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