GENENTECH PATIENT SUPPORT SERVICES

Evrysdi® Bridge Program Form
risdiplam

Phone: (833) 387-9734 | **Fax:** (833) 387-9700

M-US-00020964(v2.0)

Instructions for Patients

The Genentech Evrysdi Bridge Program offers up to 2 months of free product to qualified patients who have been previously prescribed Evrysdi and experience a delay in health insurance coverage determination when, for example, moving and changing jobs or insurance plans.

By completing this form, you can:

Continue treatment on Evrysdi for up to 2 months while awaiting a health coverage decision.

You can choose not to sign this form. However, Genentech cannot provide you with your health insurance benefits investigation and other financial assistance options without your signed authorization on page 4. Enrollment in this program does not impact your ability to gain access to Evrysdi from your health care provider or health insurance plan.

Please follow these steps to get started:

1. **Read** the "Authorization to Use and Disclose Personal Information" on pages 2 and 3.
2. **Complete, sign and date** page 4 of the Evrysdi Bridge Program Form. Please note you must sign the form to get support for your treatment.
3. **Send** in your completed form using one of the options below.

Genentech can start supporting you when **page 4** of this form is submitted by your doctor's office in one of the following ways:

Take a photo and text it to (650) 877-1111

OR

Print, complete and fax it to (833) 387-9700

Please write legibly and complete all required fields (*) on this form to avoid any delays.

Please note: Your doctor has to complete the Evrysdi Bridge Program Form before we can begin helping you.

If you have any questions, talk to your health care provider or call **(833) 387-9734**.

Helpful Terminology

Genentech: The maker of the medicine your doctor wants to prescribe. Genentech is committed to helping patients get the medicine their doctor prescribed. When used on this form, "Genentech" refers to Genentech, the Genentech Patient Foundation, and their respective partners, affiliates, subcontractors and agents.

MySMA Support™: Your support team at Genentech that works with your doctor and your health insurance plan to help you understand your insurance coverage and get your prescribed Evrysdi medicine. The Genentech MySMA team includes your Case Manager (CM), specialty pharmacy, and a Partnership and Access Liaison (PAL).

Additional Partnership and Access Liaison (PAL) Support: A local representative from Genentech that offers **optional** disease education and product support for patients at no cost to them. This may include items or materials explaining product dosing and administration for use when traveling and may also include marketing materials and information about Genentech products, services and programs. Please keep in mind that PALs are not part of your medical team, do not provide medical advice and are not substitutes for your health care provider. Your health care provider should always be your main resource for any questions about your health and medical care.

Case Manager (CM): The Genentech representative that partners closely with your health care provider, and other members of the MySMA Support team, to help you understand your health insurance coverage and potential financial support options for Evrysdi.

Alternate contact: Someone you choose to be your contact person if Genentech MySMA Support cannot reach you.

Legally authorized representative: An individual or judicial or other body authorized under applicable law to consent on behalf of a patient (e.g., parent or legal guardian of a minor).

Authorization to Use and Disclose Personal Information

I authorize my physician(s) and their staff, pharmacies, and health insurance plan (my "health care providers") to share my personal information, which may include contact information, demographic information, financial information, and information related to my medical condition, treatments, and health insurance and benefits, with Genentech, and their respective partners, affiliates, subcontractors, and agents (together, "Genentech"). I authorize Genentech to receive, use, and share my personal information in order to provide me with access to the products, services, and programs described on this form, which may include the following:

- Working with my health insurance plan to understand or verify coverage for Genentech products
- Determining my eligibility for and facilitating enrollment into financial assistance services if I'm eligible, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office. This includes contacting me to discuss my coverage, costs and eligibility for assistance and other program administration purposes
- Facilitating my access to Genentech products
- Ensuring quality and safety and improving our products and services

Authorization to Use and Disclose Personal Information (cont)

- Contacting me by mail, e-mail, telephone calls and text messages at the number(s) and address(es) provided for non-marketing purposes
- If I agree to the **optional** Consent for Patient Resources and Information, providing me with **optional** disease information and marketing material about products, services and programs offered by Genentech, its partners and their respective affiliates. This includes **optional** services or engagement from Genentech MySMA Support™, which may include outreach by a PAL. This is not required to receive help from Genentech MySMA Support with understanding health insurance coverage and potential financial support programs
- If I agree to opt into marketing autodialed and texted communications, contacting me by autodialed calls and/or text messages at the phone number(s) I have provided for marketing purposes, including from a PAL. This is not required to receive help from Genentech MySMA Support with understanding health insurance coverage and potential financial support programs

I understand that this will include sharing and use of information about me that could be considered sensitive personal information, such as health conditions, but that the use of this information by Genentech is necessary to determine if I qualify for and to administer the benefits and services for which I am applying. I understand that Genentech may also share my personal information, including sensitive personal information, for the purposes described on this authorization with my health care providers, service providers, and any individual I may designate as an alternate contact. I understand that my pharmacy may receive payment or other remuneration for disclosing my personal information pursuant to this authorization. I can choose not to sign this authorization, but Genentech will not be able to provide the services to me without it. However, my health care providers may not condition either my treatment or my payment, enrollment, or eligibility for benefits on signing this authorization.

I also understand and agree that:

- This authorization is valid for 6 years from the date I sign or the date I last enrolled, whichever comes first, unless a shorter period is required by law, or I revoke it earlier
- My personal information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Genentech will only use and share my personal information for the purposes stated on this authorization or as otherwise permitted by law
- I have the right to revoke (cancel) this authorization at any time by submitting a written notice to: Genentech Access Solutions, 1 DNA Way, South San Francisco, CA 94080-4990. If I revoke this authorization, I will no longer be eligible for the services described. If a health care provider is disclosing my personal information to Genentech on an authorized, ongoing basis, my revocation will be effective with respect to such health care provider when they receive notice of my revocation. My revocation will not impact uses and disclosures of my personal information that have already occurred in reliance on this authorization
- More information on my privacy rights, including specific rights I may have as a resident of certain states, can be found in Genentech's **Privacy Policy (www.gene.com/privacy-policy)**
- I have a right to receive a copy of this authorization

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*Required field M-US-00020964(v2.0)

Patient Information (to be completed by patient or their legally authorized representative)

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

Home phone: ( ) - Cell phone: ( ) -

☐ OK to leave a detailed message? Date of birth (MM/DD/YYYY): ☐ / ☐ / _____

Email address: _____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Alternate Contact (**optional**) Full name: _____

Relationship: _____ Phone: ( ) -

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Consent for Patient Resources and Information (OPTIONAL)

Genentech offers disease education and product support for patients, including items or marketing materials explaining the product and how to take it, use when traveling with the product and other information about Genentech products, services and programs. You do not have to sign up for these resources and support to get help with your insurance coverage or to learn about financial assistance options. Signing up here allows you to be contacted using the information you provide on this form. These marketing materials and support are optional, free and may be provided by a PAL, Genentech's partners and their respective affiliates. PALs do not provide medical advice. Your healthcare provider should always be your main resource for any questions about your health and medical care.

☐ By checking this box, I agree to receive disease education materials and product support services, including outreach by a PAL. I understand that I don't have to opt into this offer and my decision does not affect receiving my medicine or financial support information. It may be necessary to use my sensitive personal information to provide me with relevant material. I also understand that I may opt out of receiving this information at any time by calling **(877) 436-3683**.

☐ By checking this box, I agree to receive autodialed calls and text messages, which may include marketing communications about Evrysdi from and on behalf of Genentech, including from a PAL, at the phone number(s) provided. I understand that choosing to receive these messages is voluntary and is not a requirement of any purchase or program enrollment. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or calling **(877) GENENTECH**/(877) 436-3683. I am also agreeing to the **Privacy Policy (www.gene.com/privacy-policy)** and **SMS Terms & Conditions (www.gene.com/terms-conditions/sms-text-message-program-terms-conditions).**

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Evrysdi Bridge Program Terms and Conditions

The Evrysdi Bridge Program provides eligible, insured patients who are experiencing an insurance coverage determination delay with one free ~30-day supply of Evrysdi. If the patient experiences a persistent insurance coverage determination delay, the patient may be eligible for one ~30-day refill of Evrysdi. Participation in the Bridge Program is not contingent on any past or future purchase and does not obligate use or continuing use of any specific product. If the patient has received free product via the Starter Program, the patient may not participate in the Bridge Program. Requests for the Evrysdi Bridge Program cannot be processed without completed and signed Bridge Program Request Form, which includes: 1) Evrysdi Bridge Prescriber Service Form and 2) Patient Bridge Consent Form. Patients must be prescribed Evrysdi for a valid FDA-approved indication. Neither the prescriber, the pharmacy, nor any patient receiving free medicine via the Evrysdi Bridge Program may seek payment, reimbursement, or credit for any part of the benefit received by the patient through this offer from any insurer, health plan, or government program.

The Evrysdi Bridge Program cannot be counted towards any out-of-pocket costs under any plan (such as true out-of-pocket cost under a Medicare Part D prescription drug plan). The Evrysdi Bridge Program Enrollment Team may notify the patient's insurer that the patient is receiving a free supply of medicine from the Program. Prescribers may not advertise or otherwise use the Program as a means of promoting their services or Genentech's medicines to patients. This Program is void where prohibited by law and may not be used in or by residents of restricted states, where applicable. The free supply may not be sold, purchased or traded or offered for sale, purchase or trade. This Program is not a benefit plan. Genentech reserves the right to rescind, revoke or amend the program without notice at any time.

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REQUIRED

By signing this form, I acknowledge that I have provided accurate and complete information and understand and agree to the terms of this form. My signature certifies that I have read, understood, and agree to the release and use of my personal information, including sensitive personal information, pursuant to the Authorization to Use and Disclose Personal Information and as otherwise stated on this form.

Sign and date here

_____ ☐ / ☐ / _____

***Signature of Patient/Legally Authorized Representative**
(A parent or guardian must sign for patients under 18 years of age)

***Date signed**
(MM/DD/YYYY)

Person signing (if not patient)

_____ _____ _____

Print first name **Print last name** **Relationship to patient**

Once this page has been completed, please text a photo to **(650) 877-1111** or fax to **(833) 387-9700**.

If this is an electronic consent, you understand that by typing your name and date above and submitting, or taking a picture and sending to us, that you are providing your consent electronically and that it has the same force and effect as if you were signing in person on paper. Genentech reserves the right to rescind, revoke or amend the program without notice at any time.

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Instructions for Health Care Providers

The Genentech Evrysdi Bridge Program offers up to 2 months of free product to qualified patients who have been previously prescribed Evrysdi and experience a delay in health insurance coverage determination when, for example, moving and changing jobs or insurance plans.

By completing this form, you are requesting services on behalf of your patient, which may include:

- Insurance benefits investigation
- Resources for prior authorizations and appeals
- Their continued treatment on Evrysdi for up to 2 months while awaiting a health coverage decision

To enroll your patient, please follow these steps:

1. **Have your patient read pages 2 and 3**
2. **Have your patient complete the Patient Information on page 4 and sign and date Section 3.**
   - If your patient is requesting **optional** disease education and other material, including **optional** services from Genentech MySMA Support™, they should also complete Section 1
3. **Complete page 6, ensuring to sign and date Section 7**
4. **Submit pages 4 and 6** via fax to **(833) 387-9700**
   - Page 4 can also be submitted by text to **(650) 877-1111**

Please write legibly and complete all required fields (*) on this form to avoid any delays.

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Prescriber Information (to be completed by the prescriber)

STEP 1 — Patient Information

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

*Date of birth (MM/DD/YYYY): ___/___/_____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

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

Home phone: (___) ___-_____ Cell phone: (___) ___-_____ ☐ Do not contact patient

Alternate contact name: _____ Relationship: _____ Alt. phone: (___) ___-_____

STEP 2 — Insurance Information

Please complete the information below or attach a copy of the patient's medical and prescription insurance cards.

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

☐ Patient is currently pursuing coverage for their medicine and currently experiencing a gap in therapy.

Current gap in coverage: ☐ Pending prior authorization ☐ Pending appeal ☐ Pending establishment of coverage

STEP 3 — Evrysdi Bridge Program (Signature Required)

Dispense: 1-shipment supply. ☐ Oral solution ____ mg (____mL) once daily **OR** ☐ 5 mg once daily

☐ 5-mg tablet

☐ 1-time refill. Weight-based dosing will require a new Rx.

☐ Your signature authorizes the specialty pharmacy to dispense needed ancillary supplies for enteral administration of this medication, such as: ENFit® adapters, oral syringes, cassettes, administration sets, and tubing.

STEP 4 — Diagnosis and Clinical Information

*Diagnosis code(s): ☐ G12.0 Infantile spinal muscular atrophy, type I ☐ G12.1 Other inherited spinal muscular atrophy

☐ G12.9 Spinal muscular atrophy, unspecified ☐ Other: _____

SMA type: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 *SMN2* copy number: _____ Patient weight: _____ ☐ lbs ☐ kgs Date measured: ___/___/_____

Has patient taken Evrysdi? ☐ Yes ☐ No Expected Evrysdi treatment start date: ___/___/_____

Previous therapy: ☐ Spinraza® (nusinersen) last dose: ___/___/_____ ☐ Zolgensma® (onasemnogene abeparvovec-xioi) last dose: ___/___/_____

☐ Other: _____ last dose: ___/___/_____ ☐ Drug and non-drug allergies: _____ ☐ No known allergies

STEP 5 — Prescription Information

Solution/Strength	Directions	Route	Quantity	Refills
☐ .75 mg/mL 80 mL ☐ 5-mg tablet	☐ Oral solution _____mg (_____mL) **OR** ☐ 5 mg once daily ☐ SIG: _____	☐ Oral ☐ Feeding tube Type: _____	☐ 1-month supply ☐ Other: _____	_____

STEP 6 — 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 https://www.gene.com/privacy-policy.

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)** I 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; **(c)** I will not attempt to seek reimbursement for free product provided to the patient and I agree to all terms and conditions of such program; **(d)** I request Genentech Access Solutions convey to the pharmacy chosen by the above-named patient the prescription described herein; **(e)** the services I am requesting on behalf of the patient may include benefits investigations (BI), and prior authorization support (PA); **(f)** no action on these services will be taken until the patient consent document has been received; **(g)** I must comply with all state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc; I understand that noncompliance with state-specific requirements could result in outreach to me; **(h)** my patient meets the criteria for the Genentech Evrysdi Bridge Program; **(i)** I understand that Genentech reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted.

Sign, date & fax to **(833) 387-9700**

_____ ___/___/_____ **OR** _____ ___/___/_____

*Prescriber Signature — Dispense as Written (Original signature required) *Date *Prescriber Signature — Generic Substitution Permitted (Original signature required) *Date

†National Provider Identifier.

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