GENENTECH PATIENT SUPPORT SERVICES

www.evrysdi.com/forms | **Phone:** (833) 387-9734 | **Fax:** (833) 387-9700

Evrysdi® Start Form
risdiplam

M-US-00001154(v3.0)

Instructions for Health Care Providers

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

- Insurance benefits investigation
- Resources for prior authorizations (PA) and appeals
- Referral of eligible patients to co-pay support options or the Genentech Patient Foundation

To enroll your patient, please follow these steps:

1. Have your patient read pages 2 and 3.
2. Have your **patient complete page 4** and sign and date Section A. If your patient is requesting other optional services from Genentech MySMA Support™, they should also sign and date Section B. If your patient is requesting free medicine from the Genentech Patient Foundation, they should also sign and date Section C. Only Section A is required for insurance coverage and financial assistance options support.
3. **Complete page 5 and sign and date** the Health Care Provider Certification.
4. **Submit pages 4 and 5 of the Start Form** via fax to (833) 387-9700. Page 4 of the Start Form can also be submitted by text to (650) 877-1111 as indicated below.

Instructions for Patients

By completing this form you can:

Learn about your health insurance coverage and financial assistance options through Genentech MySMA Support.

Enroll in other optional services from Genentech MySMA Support that provide disease education and resources about the Genentech medicine you are prescribed.

We can start assisting you once this form is sent back to us by you or your health care provider on your behalf.

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

Please follow these steps to get started:

Read the "About Your Consent" section on page 3.

Complete, sign and date page 4 of the Evrysdi Start Form. You can also complete and sign this form **online** at www.evrysdi.com/forms.

Your health care provider should complete page 5 of the Evrysdi Start Form and **submit both pages 4 and 5** via fax.

If you complete this form outside of your doctor's office, you may submit a picture of the completed Start Form (page 4 only) to (650) 877-1111.

Please write legibly and complete all required fields (*) on the Evrysdi Start Form to avoid any delays.

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 provider wants to prescribe. Genentech is committed to helping patients get the medicine their provider prescribed.

MySMA Support™: Your support team at Genentech that works with your doctor and your health insurance plan to help you get your prescribed Evrysdi therapy. Optional services from MySMA Support can also provide disease education and relevant resources. This team includes your Partnership and Access Liaison (PAL), Case Manager (CM) and specialty pharmacy (SP).

Partnership and Access Liaison (PAL): Is your go-to person that educates patients regarding how to properly administer Evrysdi. PALs may also provide education regarding Evrysdi's safety and efficacy profile, the insurance approval process, financial support services and more. PAL services are offered in-person and virtually. Only your health care provider can give you medical advice about your disease and treatment.

Case Manager (CM): The Genentech representative that partners closely with the PAL and your health care provider to help understand your health insurance coverage and potential financial support options for Evrysdi.

Specialty pharmacy (SP): Specialty pharmacies manage drugs that need special handling or storage, such as Evrysdi. The SP will directly ship Evrysdi to you. Prior to shipping your monthly Evrysdi the SP will call to confirm your address and other logistics. It is very important you answer its call to avoid any delays in receiving your treatment.

Genentech Patient Foundation: A program that gives free Genentech medicine to people who don't have insurance coverage or who have financial concerns and meet certain eligibility criteria.

Household size: Number of people living in your household, including you.

Household income: How much you and the members of your household make each year minus specific deductions. This is also frequently referred to as your adjusted gross income or AGI. This information is needed to determine Genentech Patient Foundation eligibility.

Deductible: The amount you pay out of pocket for your health care services or medicines before your health insurance plan begins to pay.

Out-of-pocket costs: The amount not paid by your insurance plan that you must pay for your treatment. This includes deductibles, co-pays and co-insurance.

Co-pay assistance: Programs available to help eligible patients pay for their medicines.

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

Personally identifiable information (PII): Any information that can be used to directly or indirectly identify you or your household. This might include your name, date of birth, address, telephone number, email address, financial information, medical condition, or information about your health benefits or insurance coverage.

If I receive free Genentech medicine from the Genentech Patient Foundation

- I will not sell or give out this medicine since it is unlawful to do so. I am responsible to make sure these medicines are sent to a secure address when shipped to me, and I must control any Genentech medicine that I receive
- I understand that, for purposes of an audit, the Genentech Patient Foundation could ask me for a copy of my IRS 1040 form or other proof of income

About Your Consent

Who May See and Use My PII

I authorize Genentech and/or Genentech Patient Foundation to (i) use my PII for the purpose of facilitating my access to Genentech products and providing the services described below, and (ii) further disclose my PII to others who are assisting them in these services, and to my health care provider(s), health care entities, pharmacies, and health plan(s) for purposes of providing these services. If I am a resident of California, additional information regarding my privacy rights can be found on Genentech's website privacy policy (www.gene.com/privacy-policy).

Reasons for sharing and using my information may include:

- Working with my health care plan to understand coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility for, and enrollment, in financial assistance services, including co-pay assistance
- Coordinating my prescription through a pharmacy, and/or health care provider
- Providing treatment reminders and education

I direct and authorize my physician, pharmacy and my health plan(s) to disclose my PII to Genentech and its partners, as necessary for Genentech to provide the above services. I understand that Genentech may provide remuneration to my pharmacy in exchange for the disclosure of my PII, provided that Genentech's agreement with my pharmacy will prohibit further sale of my PII without my permission.

Once I sign this Patient Consent Form and my PII is transmitted to Genentech and/or Genentech Patient Foundation, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect or prohibit the redisclosure of the PII disclosed to Genentech and/or Genentech Patient Foundation by my health care provider or others covered by the HIPAA laws. I understand that Genentech and Genentech Patient Foundation are committed to protecting my information and keeping it secure and confidential while it is being collected or used to assist me and that the use and disclosure of my information will be limited to that described above. I can choose not to sign this form, but Genentech and Genentech Patient Foundation will not be able to assist me without it. However, my health care providers and health insurer may not condition either my treatment or my payment, enrollment or eligibility for benefits on signing this form.

The length and terms of this form

- This form is valid for 3 years from the date I signed or the date I last enrolled, whichever comes first, unless a shorter period is required by law. I agree that if I reside in the state of Maryland, this form will be valid for no longer than 1 year from the date I signed
- I have the right to cancel this authorization. If I cancel, this means that Genentech and/or the Genentech Patient Foundation will no longer use or share my PII, but this will not apply to PII already used or shared or when it is required by law. If I reside in California, I also have the right to request that Genentech and/or the Genentech Patient Foundation delete my PII, although deletion is not required under certain circumstances. To cancel or request deletion, I must send a written notice to Genentech. It can be sent by fax or by mail to Genentech, 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990. If I cancel and request deletion, I know that Genentech and the Genentech Patient Foundation will no longer be able to assist me with access to my Genentech products
- I understand that I, as the patient or signer, have a right to receive a copy of this signed form over the time it is valid

Patient Consent Form — To be completed by patient or his/her legally authorized person

*First name: _____ *Last name: _____

Date of birth: ☐/☐/_____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Home phone: (_____) _____ - _____ Cell phone†: (_____) _____ - _____

☐ OK to leave a detailed message? ☐ OK to send a text? Email: _____

Alternate contact name: _____

Relationship: _____ Alt. phone: (_____) _____ - _____

Section A

Patient consent via signature is **required** to obtain insurance benefit information and financial assistance through Genentech MySMA Support™ and the Genentech Patient Foundation. By signing this section, I agree to the terms listed in "About Your Consent" on page 3.

Sign and date here _____ ☐/☐/_____

*Patient/Authorized Person Signature — *Date (MM/DD/YYYY)

A parent or guardian must sign for patients under 18 years of age

Person signing (if not patient) _____ _____ _____

Print First Name | Print Last Name | Relationship

Section B

Patient consent to enroll in **optional** Genentech MySMA Support including disease education, support programs, research and communications that may be considered marketing. I understand my PII may be needed for me to participate in these programs.

Sign and date here _____ ☐/☐/_____

Patient/Authorized Person Signature — **Date** (MM/DD/YYYY)

A parent or guardian must sign for patients under 18 years of age

†By providing my phone number and signing Section B, I authorize Genentech to use auto-dialers, prerecorded messages and artificial voice messages to contact me. I understand that these calls/texts may mention the name of Genentech products or services, details about my insurance coverage and my doctor's name. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of Genentech products or enrollment.

Section C

Financial eligibility information **required** for the **Genentech Patient Foundation**. By completing this section, I am attesting the information below and am agreeing to the terms and conditions of the Genentech Patient Foundation outlined on page 2.

Household size (including you): _____ Annual household income: ☐ Under $75,000 ☐ $75,000–$100,000 ☐ $100,001–$125,000 ☐ $125,001–$150,000 ☐ Over $150,000

Sign and date here _____ ☐/☐/_____

Patient/Authorized Person Signature — **Date** (MM/DD/YYYY)

A parent or guardian must sign for patients under 18 years of age

Once this page (4 of 5) has been completed, please text a photo of page 4 to (650) 877-1111, or fax to (833) 387-9700. This form can also be completed online at www.evrysdi.com/forms

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risdiplam

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*Required field M-US-00001154(v3.0)

Prescriber Service Form — 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

Is the patient insured? ☐ Yes ☐ No

If insured, please fill out the information below or attach a copy (front and back) of the patient's medical and prescription insurance cards and skip to step 3. ☐ COPY OF INSURANCE CARD(S) ATTACHED

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

Step 3 Diagnosis and Clinical Information

*Diagnosis code(s): ☐ G12.0 Infantile spinal muscular atrophy type 1 ☐ G12.1 Other inherited spinal muscular atrophy
☐ G12.9 Spinal muscular atrophy, unspecified ☐ Other: _____

SMA type: ☐ 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 4 Prescription Information

Strength	Directions	Route	Quantity	Refills
Evrysdi® (risdiplam) 0.75 mg/mL 80 mL (in 100 mL bottle)	☐ ____ mg (____ mL) once daily ☐ 5 mg (6.6 mL) once daily ☐ SIG: _____	☐ Oral ☐ Feeding tube Type: _____	☐ 1-month supply ☐ Other: _____	

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: (_____) _____ - _____

Step 6 Evrysdi Start Program (Signature Required)

☐ I approve the dispensing of up to 2 free shipments of Evrysdi to my patient if they experience an insurance coverage delay and otherwise meet eligibility criteria. For full eligibility criteria, please speak to your Evrysdi representative.

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 I am prescribing a Genentech product is not listed in the FDA-approved label, I am 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)** 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 and **(d)** 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. **(e)** The services you are requesting on behalf of the patient, may include benefits investigation (BI), prior authorization support (PA), 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. **(g)** Prescribers must comply with all state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber. **(h)** My patient meets the criteria for Genentech Patient Foundation (GPF). **(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. **(j)** I understand that the GPF does not provide free drug in the instance of an administrative error or a coverage restriction, such as a step edit. For certain products where the step edit may not be medically appropriate, as confirmed by the prescribing physician, the GPF may consider support following 1 level of appeal.

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.