Patient Consent Form—to be filled out by patient

SECTION 1: Patient Information

_____
First name*

_____
Last name*

_____ /_____ /_____
Date of birth* (MM/DD/YYYY)

Preferred form of communication
(check all that apply)

☐ Email: _____

☐ Home phone‡: (_____)_____-_____

☐ Cell phone‡: (_____)_____-_____

A detailed message can be left to all numbers provided and/or all authorized individuals.

OK to leave detailed voice message?
☐ Yes ☐ No

OK to send a text message?
☐ Yes ☐ No

Best time to reach me:
☐ Morning ☐ Afternoon

_____
Patient preferred language

_____
Alternate contact name

_____
Relationship to patient

Phone: (_____)_____-_____

Email: _____

1A

Patient authorization via signature is required to obtain services from Genentech Access Solutions for ENSPRYNG and Genentech Patient Foundation. By signing this box, you agree to the terms in the "About Your Consent" section.

Sign and date here

_____ _____ /_____ /_____
Signature of patient/authorized person* Date signed* (MM/DD/YYYY)

_____ _____
Print first name† Print last name†

_____
Relationship to patient (required if not the patient)

1B

Patient consent to enroll in:
☐ Injection Training Program
☐ Educational and marketing programs, which includes market research and communication that may be considered marketing

I understand that my PII may be needed for me to participate in these programs.

Choose to enroll by signing and dating here

_____ _____ /_____ /_____
Signature of patient/authorized person Date signed (MM/DD/YYYY)

‡By providing my phone number and signing Section 1B, I authorize Genentech to use auto-dialers or prerecorded and artificial voice 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. Message and data rates may apply. I understand that I may opt out of receiving these communications at any time by calling (877) GENENTECH (877-436-3683).

1C

Financial Eligibility Information: Complete for Genentech Patient Foundation only.
By completing this section, I 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

Choose to enroll by signing and dating here

_____ _____ /_____ /_____
Signature of patient/authorized person Date signed (MM/DD/YYYY)

(Required if requesting assistance from the Genentech Patient Foundation)

Genentech | ACCESS SOLUTIONS
A Member of the Roche Group

for ENSPRYNG™
satralizumab-mwge

ENSPRYNG Start Form

Phone: (844) 677-7964 Fax: (844) 677-0010 Text: (650) 877-1111
Genentech-Access.com/ENSPRYNG M-US-00003211(v1.0) 08/20
*Required field.

Prescriber Service Form—to be filled out by health care provider

SECTION 2: Patient Information

☐ DO NOT CONTACT PATIENT

First name* _____ Last name* _____

Date of birth* (MM/DD/YYYY) ____/____/____ Gender: ☐ Male ☐ Female

Street _____ City _____

State* _____ ZIP _____ Phone* (____)____-____

SECTION 3: Insurance Information

☐ NO INSURANCE

☐ COPY OF INSURANCE CARD(S) ATTACHED

If insured, please fill out information below **or** attach a copy of the patient's insurance card(s) and skip to Section 4.

☐ PA IN PLACE (AUTH #): _____

Primary insurance name _____ Phone (____)____-____

Subscriber name _____

Subscriber/Policy ID # _____

Group # _____

Secondary insurance name _____ Phone (____)____-____

Subscriber name _____

Subscriber/Policy ID # _____

Group # _____

SECTION 4: Prescriber Information

First name* _____ Last name* _____

Practice name* _____

Street* _____ Suite # _____

City* _____ State* _____ ZIP* _____

Prescriber tax ID # _____ Prescriber NPI # _____

Group NPI # _____ Office contact name _____

Office contact phone (____)____-____ Fax (____)____-____

PA=Prior authorization.
NPI=National Provider Identifier.

SECTION 5: Acquisition/Fulfillment of Drug

☐ Specialty Pharmacy (SP) Preferred SP: _____

☐ Please conduct benefits investigation to determine procurement method

SECTION 6: Diagnosis Code and Clinical Information

Diagnosis code*: ☐ G36.0 Neuromyelitis optica [Devic]

☐ Other diagnosis code: _____

Has the patient started prescribed ENSPRYNG™ (satralizumab-mwge)? ☐ Yes ☐ No

SECTION 7: ENSPRYNG Prescription

☐ Drug allergies: _____ ☐ None

Other medications: _____

Dispense: (1) prefilled syringe

☐ Initial dose SIG: Inject 120 mg once every 2 weeks for 1 month Refills: 2

☐ Maintenance dose SIG: Inject 120 mg every 4 weeks Refills: _____

BY COMPLETING THIS FORM: I am requesting services on behalf of the patient, which may include benefits investigation and reverification, help navigating the PA process and appeals support.

By signing 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 you are prescribing a Genentech product is not listed in the FDA-approved label, you are 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) For prescribers in states with official prescription form requirements, such as New York, prescriptions must be submitted on an official state prescription pad along with this enrollment form.

Sign and date here

_____ ____/____/____
Prescriber's Signature Date (MM/DD/YYYY)
(Original signature required for specialty pharmacy support only. No signature required for other services.)