

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
 Preferred language: English Spanish Other: _____
 Alternate contact name: _____ Relationship: _____ Alt. phone: (____) _____ - _____

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.

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

Step 3 Diagnosis and Clinical Information

*To the highest level of specificity, provide diagnosis code:
 E84.0 Cystic fibrosis with pulmonary manifestations E84.8 Cystic fibrosis with other manifestations
 E84.9 Cystic fibrosis, unspecified Other code: _____
 *Prescription type: New start Continuing therapy Restart therapy Has patient started therapy? Yes No
 Anticipated date of treatment: ____ / ____ / ____

Step 4 Prescription Information

Pulmozyme regimen 2.5 mL (dornase alfa) inhalation solution
 Dispense: 30-day supply 60-day supply 90-day supply Refill _____ times SIG: QD BID

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 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 card and co-pay assistance foundation referral. **(f) No action on these services will be taken until the patient consent document has been received.**

[†]National Provider Identifier.
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