

STATEMENT OF MEDICAL NECESSITY (SMN) for LUCENTIS® (ranibizumab injection)

Please write legibly and complete all required fields (*) to prevent delays.

Phone: (866) 724-9394 Fax: (866) 724-9412 Genentech-Access.com/LUCENTIS

ACS/062315/0106 08/15

SERVICES REQUESTED*
(check only those that apply)

- Benefits Investigation/Prior Authorization
 GATCF¹ Patient Assistance

- Appeals Support
 GATCF Eligibility Screening

- Co-pay Assistance

PATIENT

Last name*: _____ First name*: _____ Birth date*: _____ Gender: Male Female
Street: _____ City: _____ State*: _____ ZIP: _____
Home phone: (____) _____ Work/cell phone: (____) _____ **OK to contact patient?** Yes No Pt. preferred language (if other than English): _____

INSURANCE

Insurance card attached (optional: see page 2 for details)

- HMO/EPO PPO POS Indemnity
 Medicare/Medicaid PBM Pending Medicaid No insurance

Primary insurance (PI) name: _____
PI phone: _____
PI subscriber name: _____
PI subscriber ID #: _____
Policy/group #: _____

- HMO/EPO PPO POS Indemnity
 Medicare/Medicaid PBM Pending Medicaid No insurance

Secondary insurance (SI) name: _____
SI phone: _____
SI subscriber name: _____
SI subscriber ID #: _____
Policy/group #: _____

DIAGNOSIS/TREATMENT

Anticipated date of treatment: _____

Eye(s) being treated (check all that apply): Rt Lt

- | Primary | Secondary | Diagnosis code* |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Wet age-related macular degeneration (wAMD)
H35.32 Exudative age-related macular degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> | Retinal vein occlusion (RVO) |
| <input type="checkbox"/> | <input type="checkbox"/> | H35.81 Retinal edema |
| <input type="checkbox"/> | <input type="checkbox"/> | H34.811 Central RVO, right eye |
| <input type="checkbox"/> | <input type="checkbox"/> | H34.812 Central RVO, left eye |
| <input type="checkbox"/> | <input type="checkbox"/> | H34.813 Central RVO, bilateral |
| <input type="checkbox"/> | <input type="checkbox"/> | H34.819 Central RVO, unspecified eye |
| <input type="checkbox"/> | <input type="checkbox"/> | H34.831 Tributary (branch) RVO, right eye |
| <input type="checkbox"/> | <input type="checkbox"/> | H34.832 Tributary (branch) RVO, left eye |
| <input type="checkbox"/> | <input type="checkbox"/> | H34.833 Tributary (branch) RVO, bilateral |
| <input type="checkbox"/> | <input type="checkbox"/> | H34.839 Tributary (branch) RVO, unspecified eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetic macular edema (DME) and diabetic retinopathy (nonproliferative [NPDR] and proliferative [PDR]) with DME |
| <input type="checkbox"/> | <input type="checkbox"/> | E08.311 Diabetes due to underlying condition with unspecified diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E08.321 Diabetes due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E08.331 Diabetes due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E08.341 Diabetes due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E08.351 Diabetes due to underlying condition with proliferative diabetic retinopathy with macular edema |

- | Primary | Secondary | Diagnosis code* |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | DME and diabetic retinopathy (NPDR and PDR) with DME (cont) |
| <input type="checkbox"/> | <input type="checkbox"/> | E10.311 Type 1 diabetes with unspecified diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E10.321 Type 1 diabetes with mild nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E10.331 Type 1 diabetes with moderate nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E10.341 Type 1 diabetes with severe nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E10.351 Type 1 diabetes with proliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E11.311 Type 2 diabetes with unspecified diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E11.321 Type 2 diabetes with mild nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E11.331 Type 2 diabetes with moderate nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E11.341 Type 2 diabetes with severe nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E11.351 Type 2 diabetes with proliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E13.311 Other specified diabetes with unspecified diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E13.321 Other specified diabetes with mild nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E13.331 Other specified diabetes with moderate nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E13.341 Other specified diabetes with severe nonproliferative diabetic retinopathy with macular edema |
| <input type="checkbox"/> | <input type="checkbox"/> | E13.351 Other specified diabetes with proliferative diabetic retinopathy with macular edema |
- Other code(s): _____

PRESCRIPTION

LUCENTIS® (ranibizumab injection): Drug allergies: _____ NKDA

DISPENSE: _____ vial(s) 0.05 mL of a 10-mg/mL solution
 SIG: Inject 0.5 mg (0.05 mL) intravitreally monthly
 SIG: Inject 0.5 mg (0.05 mL) intravitreally monthly x4 months then quarterly
 SIG: Inject 0.5 mg (0.05 mL) intravitreally monthly x3 months then as needed (PRN)
 SIG: _____ Refill: _____ times

DISPENSE: _____ vial(s) 0.05 mL of a 6-mg/mL solution
 SIG: Inject 0.3 mg (0.05 mL) intravitreally monthly
 SIG: _____
Refill: _____ times

Specialty pharmacy needed for dispensing: Yes No (MD office will supply) Preferred specialty pharmacy: _____
Ship to address (if different from office shown below): _____

PRESCRIBER

Prescriber's last name*: _____ First name*: _____
Practice name: _____ Specialty: _____
Street*: _____ City*: _____ State*: _____ ZIP*: _____
Phone: (____) _____ Fax: (____) _____
Prescriber tax ID: _____ Prescriber NPI³: _____
DEA #: _____ Group NPI: _____ State license #*: _____ PTAN⁵: _____
Reimbursement/clinical contact last name: _____ First name: _____
Reimbursement/clinical contact phone: (____) _____ Fax: (____) _____

UNAPPROVED USE WARNING: Please read the FDA-approved label for LUCENTIS before prescribing. If the indication for which you are prescribing LUCENTIS is not listed in the label, you are prescribing LUCENTIS for an "unapproved" use. The fact that the use for which you are prescribing LUCENTIS is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of LUCENTIS when used for such a use. Nevertheless, GATCF will consider providing LUCENTIS for your patient with this admonition, based upon your medical order, within program requirements.

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Genentech, Inc., LUCENTIS Access Solutions and contracted dispensing pharmacy or other contractors for the purpose of requesting reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Genentech products, as a break in treatment would negatively impact the patient's therapeutic outcome and (c) I will not attempt to seek reimbursement for free product provided directly to the patient. I request LUCENTIS Access Solutions convey to the pharmacy chosen by the above-named patient the prescription described herein.

I agree to comply with the program guidelines as established by Genentech, Inc. and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted. I further understand that Genentech will provide vital replacement in a configuration that will create the least amount of wastage.

If applying for GATCF, I certify that this patient has no medical insurance coverage or otherwise meets the financial criteria for the pharmaceutical identified above and is not eligible for other public health insurance programs.

Special Note: Prescribers in all states must follow applicable law for a valid prescription. For prescribers in states with official prescription form requirements, such as New York, please submit prescriptions on an official state prescription blank along with this form.

Sign and date here

Prescriber's Signature*: _____ Date*: _____
(Original signature required.)

*Required field. ¹Genentech® Access to Care Foundation. ³National Provider Identifier. ⁵Provider Transaction Access Number.

STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays. Complete this form online via My Patient Solutions™, our online patient management tool. Visit Genentech-Access.com/LUCENTIS to register for My Patient Solutions.

SERVICES REQUESTED

- Check the appropriate services requested on behalf of the patient. LUCENTIS Access Solutions and/or GATCF cannot perform services without your specific request

DIAGNOSIS/TREATMENT

- Please check either “yes” or “no.” If the patient has not started treatment, enter the anticipated date of the first treatment
- Check the appropriate diagnosis code
 - Be sure to indicate if the diagnosis is primary or secondary by checking the appropriate box next to the ICD-10-CM code
 - If “Other” is checked, list all appropriate codes on the line provided, indicating which is the primary and which is the secondary code in writing
 - Check the appropriate box to indicate the eye(s) affected
- For dates of service prior to October 1, 2015, ICD-9-CM codes must be used. For dates of service on or after October 1, 2015, only ICD-10-CM codes will be accepted

Note: These codes are not all-inclusive. Commercial payers as well as Medicare and Medicaid may choose their own codes. This guide is provided for informational purposes only. Correct coding is the responsibility of the provider submitting a claim for the item or service. Please check with individual payers to verify codes and special billing requirements. Genentech does not make any representation or guarantee concerning coverage or payment for any service or item.

PRESCRIPTION

- Please ensure you complete all areas of the prescription portion clearly and completely
- LUCENTIS is available in vials of a 6-mg/mL or 10-mg/mL solution
- LUCENTIS for DME can be dosed monthly using 0.3 mg; 0.5 mg monthly for RVO and monthly with regular assessment for wAMD
- LUCENTIS should be refrigerated at 2-8° C (36-46° F). Please indicate where to send shipments (if different from the prescriber address) to ensure the drug will be stored appropriately

PRESCRIBER

- This form cannot be processed without an original or stamped signature

ATTACH TO COMPLETED SMN

- Attach a signed and dated Patient Authorization and Notice of Release of Information (PAN) form. LUCENTIS Access Solutions and/or GATCF cannot work with the insurance plan on your patient’s behalf without a signed and dated PAN form
- If the patient is insured, provide a front and back copy of the patient’s drug card

PROVIDING ADDITIONAL DOCUMENTS OR INFORMATION WITH THIS FORM, OTHER THAN WHAT IS REQUESTED, WILL DELAY PROCESSING.

REMINDER: This form cannot be processed without a prescriber’s signature and date, as well as a signed and dated PAN form.

Genentech-Access.com/LUCENTIS

Phone: (866) 724-9394 Fax: (866) 724-9412

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RANIBIZUMAB INJECTION