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

LUCENTIS® RANIBIZUMAB INJECTION | ACCESS SOLUTIONS®

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
- ☑ GATCF† 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*
		Wet age-related macular degeneration (wAMD)
☐	☐	**H35.32** Exudative age-related macular degeneration
		Retinal vein occlusion (RVO)
☐	☐	**H35.81** Retinal edema
☐	☐	**H34.811** Central RVO, right eye
☐	☐	**H34.812** Central RVO, left eye
☐	☐	**H34.813** Central RVO, bilateral
☐	☐	**H34.819** Central RVO, unspecified eye
☐	☐	**H34.831** Tributary (branch) RVO, right eye
☐	☐	**H34.832** Tributary (branch) RVO, left eye
☐	☐	**H34.833** Tributary (branch) RVO, bilateral
☐	☐	**H34.839** Tributary (branch) RVO, unspecified eye
		Diabetic macular edema (DME) and diabetic retinopathy (nonproliferative [NPDR] and proliferative [PDR]) with DME
☐	☐	**E08.311** Diabetes due to underlying condition with unspecified diabetic retinopathy with macular edema
☐	☐	**E08.321** Diabetes due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema
☐	☐	**E08.331** Diabetes due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema
☐	☐	**E08.341** Diabetes due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema
☐	☐	**E08.351** Diabetes due to underlying condition with proliferative diabetic retinopathy with macular edema

Primary	Secondary	Diagnosis code*
		DME and diabetic retinopathy (NPDR and PDR) with DME (cont)
☐	☐	**E10.311** Type 1 diabetes with unspecified diabetic retinopathy with macular edema
☐	☐	**E10.321** Type 1 diabetes with mild nonproliferative diabetic retinopathy with macular edema
☐	☐	**E10.331** Type 1 diabetes with moderate nonproliferative diabetic retinopathy with macular edema
☐	☐	**E10.341** Type 1 diabetes with severe nonproliferative diabetic retinopathy with macular edema
☐	☐	**E10.351** Type 1 diabetes with proliferative diabetic retinopathy with macular edema
☐	☐	**E11.311** Type 2 diabetes with unspecified diabetic retinopathy with macular edema
☐	☐	**E11.321** Type 2 diabetes with mild nonproliferative diabetic retinopathy with macular edema
☐	☐	**E11.331** Type 2 diabetes with moderate nonproliferative diabetic retinopathy with macular edema
☐	☐	**E11.341** Type 2 diabetes with severe nonproliferative diabetic retinopathy with macular edema
☐	☐	**E11.351** Type 2 diabetes with proliferative diabetic retinopathy with macular edema
☐	☐	**E13.311** Other specified diabetes with unspecified diabetic retinopathy with macular edema
☐	☐	**E13.321** Other specified diabetes with mild nonproliferative diabetic retinopathy with macular edema
☐	☐	**E13.331** Other specified diabetes with moderate nonproliferative diabetic retinopathy with macular edema
☐	☐	**E13.341** Other specified diabetes with severe nonproliferative diabetic retinopathy with macular edema
☐	☐	**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*: CA ZIP*: _____

Phone: (_____) _____ Fax: (_____) _____

Prescriber tax ID: _____ Prescriber NPI‡: _____

DEA #: _____ Group NPI: _____ State license #*: _____ PTAN§: _____

Reimbursement/clinical contact last name: Madrigal First name: Lucy

Reimbursement/clinical contact phone: (951) 566-9513 Fax: (951) 672-6667

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 vial 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. †Genentech® Access to Care Foundation. ‡National Provider Identifier. §Provider 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.

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