GENENTECH PATIENT SUPPORT SERVICES

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

Evrysdi® Start Form
risdiplam

M-US-00001154(v6.0)

Instructions for Patients

By completing this form, you can:

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

Sign up to receive **optional** disease education and other material, including **optional** services from Genentech MySMA Support.

You can choose not to sign this form. However, Genentech cannot provide you with your insurance benefits investigation and other financial assistance options without your signed authorization on page 4. 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:

1. **Read** the "Authorization to Use and Disclose Personal Information" section on page 3.
2. **Complete, sign and date** page 4 of the Evrysdi Start Form. Please note you must sign the form to get support for your treatment.
3. **Send** in your completed form using one of the options below.

Genentech can start supporting you when **page 4** of this form is submitted by you or your doctor's office in one of the following ways:

Complete online by scanning this QR code or visiting **www.evrysdi.com/forms**

OR

Take a photo and text it to (650) 877-1111

OR

Print, complete and fax it to (833) 387-9700

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

Please note: Your doctor has to complete the Evrysdi Prescriber Service Form before we can begin helping you.

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 doctor wants to prescribe for you. Genentech is committed to helping patients get the medicine their doctor prescribed. When used on this form, "Genentech" refers to Genentech, Genentech Patient Foundation, and their respective partners, affiliates, subcontractors and agents.

MySMA Support™: Your support team at Genentech that works with your doctor and your health insurance plan to help you get your prescribed Evrysdi medicine. The Genentech MySMA team includes your Case Manager (CM) and specialty pharmacy (SP). If you sign up for **optional** services and materials, it also includes a Partnership and Access Liaison (PAL). **Optional** services from MySMA Support can also provide disease education and relevant resources.

Partnership and Access Liaison (PAL): An **optional** local point of contact from Genentech who supports people taking Evrysdi. PALs are here to answer questions about Evrysdi, refer you to helpful resources and help you understand your insurance and financial support options. A PAL is not part of your medical team and is not a substitute for your health care provider. PALs do not provide medical advice. Your health care provider should always be your main resource for any questions about your health and medical care.

Case Manager (CM): The Genentech representative that partners closely with your health care provider, and if you choose, the PAL, to help you 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 eligible people who don't have insurance coverage or who have financial concerns.

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

Annual 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 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.

Legally authorized representative: An individual or judicial or other body authorized under applicable law to consent on behalf of a patient (e.g., parent or legal guardian of a minor).

Terms and Conditions of the Genentech Patient Foundation

- If I receive free medicine from the Genentech Patient Foundation, I will not sell or give out the medicine because it is illegal to do so. I am responsible to ensure that the medicine is sent to a secure address when shipped to me, and I must control any 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

Authorization to Use and Disclose Personal Information

I authorize my physician(s) and their staff, pharmacies, and health insurance plan (my "health care providers") to share my personal information, which may include contact information, demographic information, financial information, and information related to my medical condition, treatments, and health insurance and benefits, with Genentech, Genentech Patient Foundation, and their respective partners, affiliates, subcontractors, and agents (together, "Genentech"). I authorize Genentech to receive, use, and share my personal information in order to provide me with access to the products, services, and programs described on this form, which may include the following:

- Working with my health insurance plan to understand or verify coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility for and facilitating enrollment into financial assistance services if I'm eligible, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office. This includes contacting me to discuss my coverage, costs and eligibility for assistance and other program administration purposes
- Facilitating my access to Genentech products
- Ensuring quality and safety and improving our products and services
- Contacting me by mail, e-mail, telephone calls and text messages at the number(s) and address(es) provided for non-marketing purposes
- If I agree to the **optional** Consent for Patient Resources and Information, providing me with **optional** disease information and marketing material about products, services and programs offered by Genentech, its partners and their respective affiliates. This includes **optional** services or engagement from Genentech MySMA Support, which may include outreach by a PAL. This is not required to receive help from Genentech MySMA Support with understanding health insurance coverage and potential financial support programs
- If I agree to the **optional** Telephone Consumer Protection Act (TCPA) Consent, contacting me by autodialed calls and/or text messages at the phone number(s) I have provided for marketing purposes, including text messages from a PAL. This is not required to receive help from Genentech MySMA Support with understanding health insurance coverage and potential financial support programs

I understand that Genentech may also share my personal information for the purposes described on this authorization with my health care providers, service providers, and any individual I may designate as an alternate contact. I understand that my pharmacy may receive payment or other remuneration for disclosing my personal information pursuant to this authorization. I can choose not to sign this authorization, but Genentech will not be able to provide the services to me without it. However, my health care providers may not condition either my treatment or my payment, enrollment, or eligibility for benefits on signing this authorization.

I also understand and agree that:

- This authorization is valid for 6 years from the date I sign or the date I last enrolled, whichever comes first, unless a shorter period is required by law, or I revoke it earlier
- My personal information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA). However, Genentech will only use and share my personal information for the purposes stated on this authorization or as otherwise permitted by law
- I have the right to revoke (cancel) this authorization at any time by submitting a written notice to: Genentech Access Solutions, 1 DNA Way, South San Francisco, CA 94080-4990. If I revoke this authorization, I will no longer be eligible for the services described. If a health care provider is disclosing my personal information to Genentech on an authorized, ongoing basis, my revocation will be effective with respect to such health care provider when they receive notice of my revocation. My revocation will not impact uses and disclosures of my personal information that have already occurred in reliance on this authorization
- More information on my privacy rights, including specific rights I may have as a resident of certain states, like California, can be found in Genentech's privacy policy (**www.gene.com/privacy-policy**)
- I have a right to receive a copy of this authorization

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*Required field M-US-00001154(v6.0)

Patient Information (to be completed by patient or their legally authorized representative)

*First name: _____ *Last name: _____

Home phone: ( ) - Cell phone: ( ) -

☐ OK to leave a detailed message? Date of birth (MM/DD/YYYY): _____

Email: _____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Alternate Contact (**OPTIONAL**) Full name: _____

Relationship: _____ Phone: ( ) -

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Financial Eligibility: Complete **only** if you are applying to the Genentech Patient Foundation

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

2

Consent for Patient Resources and Information (**OPTIONAL**)

Genentech offers **optional** and free disease education and other material for patients. This includes **optional** services or engagement from MySMA Support™, which may include outreach by a PAL. This may include information and marketing material about products, services and programs offered by Genentech, its partners and their respective affiliates. If you sign up, you will be contacted using the information you have provided.

☐ By checking this box, I agree to receive **optional** disease education and other material. This includes **optional** services or engagement from Genentech MySMA Support, which may include outreach by a PAL. I understand that I do not have to check this box to get my medicine or to get Genentech support with understanding my health insurance coverage and potential financial support programs. I also understand that I may opt out of receiving this information at any time by calling **(877) 436-3683** and this consent will remain active unless I opt out.

Telephone Consumer Protection Act (TCPA) Consent (**OPTIONAL**)

☐ By checking this box, I consent to receive autodialed marketing calls and text messages from and on behalf of Genentech at the phone number(s) I have provided, including text messages from a PAL. I understand that consent is not a requirement of any purchase or enrollment. Message frequency may vary. Message and data rates may apply. I may opt out at any time by texting STOP or calling **(877) GENENTECH**/(877) 436-3683.

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By signing this form, I acknowledge that I have provided accurate and complete information and understand and agree to the terms of this form. My signature certifies that I have read, understood, and agree to the release and use of my personal information pursuant to the Authorization to Use and Disclose Personal Information and as otherwise stated on this form.

REQUIRED

Sign and date here

_____ / /

*Signature of Patient/Legally Authorized Representative (A parent or guardian must sign for patients under 18 years of age) | *Date signed (MM/DD/YYYY)

Person signing (if not patient)

_____ Print first name | _____ Print last name | _____ Relationship to patient

Once this page (4/6) has been completed, please text a photo of the page to **(650) 877-1111** or fax to **(833) 387-9700**. You can also complete this form online at **www.evrysdi.com/forms**.

If this is an electronic consent, you understand that by typing your name and the date above and submitting, or taking a picture and sending to us, that you are providing your consent electronically and that it has the same force and effect as if you were signing in person on paper. Genentech reserves the right to rescind, revoke or amend the program without notice at any time.

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 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 the Patient Information on page 4** and sign and date Section 3:
   - Only the Patient Information and Section 3 are required for insurance coverage and financial assistance options support
   - If your patient is requesting free medicine from the Genentech Patient Foundation, they should also complete Section 1
   - If your patient is requesting **optional** disease education and other material, including **optional** services from Genentech MySMA Support™, they should also complete Section 2
3. **Complete page 6 and sign and date** the Health Care Provider Certification.
4. **Submit pages 4 and 6 of the Start Form** via fax to (833) 387-9700 or eSubmit at www.evrysdi.com/forms. Page 4 of the Start Form can also be submitted by text to (650) 877-1111 as indicated on page 1.

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

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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 of the patient's medical and prescription insurance cards.

	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: ☐ 0 ☐ 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: _____	

☐ Your signature authorizes the specialty pharmacy to dispense needed ancillary supplies for enteral administration of this medication, such as: ENFit® adapters, oral syringes, cassettes, administration sets and tubing.

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)

Dispense: 1-shipment supply.

☐ ____ mg (____ mL) once daily **OR** ☐ 5 mg (6.6 mL) once daily

☐ 1-time refill. Weight-based dosing will require a new Rx.

For full eligibility criteria and Terms and Conditions, please visit **www.genentech-pro.com/starter** or speak to your Evrysdi representative.

☐ Your signature authorizes the specialty pharmacy to dispense needed ancillary supplies for enteral administration of this medication, such as: ENFit® adapters, oral syringes, cassettes, administration sets and tubing.

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 and I agree to all terms and conditions of such program. 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.

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