

# RESPIRATORY PATIENT CONSENT FORM

Genentech | ACCESS SOLUTIONS®

A Member of the Roche Group

M-US-00004739(v2.0) 08/20

Genentech-Access.com

Phone: (866) 422-2377 Fax: (866) 480-7762

6 a.m.—5 p.m. (PT) M-F

## Instructions for Patients

### By completing this form you can:



Learn about your health insurance coverage and other options to get your Genentech medicine



Enroll into optional disease-specific education, patient support services and communication

### Please follow these 3 steps to get started:

1. Read “About Your Consent”
2. Sign and date page 3. 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 3** of this form is submitted by you or your doctor’s office in one of the following ways:



Complete online at  
Genentech-Access.com/PatientConsent

OR



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

OR



Print, complete and fax it to  
(866) 480-7762

A representative from Genentech Access Solutions or your doctor’s office will call you to tell you about your coverage, costs and support for your treatment.

If you have any questions, talk to your health care provider or contact Genentech Access Solutions.

## Helpful Terminology

**Genentech:** The maker of the medicine your doctor wants to prescribe. Genentech is committed to helping patients get the medicine their doctor prescribed.

**Genentech Access Solutions:** A team at Genentech that works with your doctor and health insurance plan to help you get your medicine.

**Genentech Patient Foundation:** A program that gives free Genentech medicine to people who don’t have insurance coverage or who have financial concerns and meet certain eligibility criteria.

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

**Household income:** How much you and the members of your household currently make each year, minus specific deductions. This is also frequently referred to as your Adjusted Gross Income (AGI). This information is needed to determine Genentech Patient Foundation eligibility.

**Education and patient support services:** Optional programs offered by Genentech to help you start and stay on your medicine. Services may vary based on your medical condition and could include co-pay assistance, clinical support, marketing communication and general disease information.

**Deductible:** The amount you pay for health care services or medicines out of pocket before your health insurance plan begins to pay.

**Out-of-pocket costs:** The amount not paid by the 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 Access Solutions cannot reach you.

## If I Receive Free Genentech Medicine From the Genentech Patient Foundation:

- I will not sell or give out this medicine since it is unlawful to do so. I am responsible to make sure these medicines are sent to a secure address when shipped to me, and I must control any Genentech 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

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## About Your Consent — This Relates to 'Box 1' on Page 3

### Your Personally Identifiable Information (PII) may include:

- Name and birthdate
- Address, telephone number and email address
- Important financial information, as necessary
- Information on your medical condition, as necessary
- Information about your health benefits or health insurance coverage

### Who may see and use my PII

I authorize Genentech and/or Genentech Patient Foundation to (i) use my PII for the purpose of facilitating my access to Genentech products and providing the services described below, and (ii) further disclose my PII to others who are assisting them in these services, and to my health care provider(s), health care entities, pharmacies, and health plan(s) for purposes of providing these services. Additional information regarding my privacy rights can be found on Genentech's website privacy policy ([www.gene.com/privacy-policy](http://www.gene.com/privacy-policy)).

### Reasons for sharing and using my information may include:

- Working with my health care plan to understand coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility and enrollment into financial assistance services, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office
- Providing treatment reminders and education

I direct and authorize my physician, pharmacy and my health plan(s) to disclose my PII to Genentech and its partners, as necessary for Genentech to provide the above services. I understand that Genentech may provide remuneration to my pharmacy in exchange for the disclosure of my PII, provided that Genentech's agreement with my pharmacy will prohibit further sale of my PII without my permission.

Once I sign this Patient Consent Form and my PII is transmitted to Genentech and/or Genentech Patient Foundation, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect or prohibit the redisclosure of the PII disclosed to Genentech and/or Genentech Patient Foundation by my health care provider or others covered by the HIPAA laws. I understand that Genentech and Genentech Patient Foundation are committed to protecting my information and keeping it secure and confidential while it is being collected or used to assist me and that the use and disclosure of my information will be limited to that described above. I can choose not to sign this form, but Genentech and Genentech Patient Foundation will not be able to assist me without it. However, my health care providers and health insurer may not condition either my treatment or my payment, enrollment or eligibility for benefits on signing this form.

### The length and terms of this form

- This form is valid for 3 years from the date I signed or the date I last enrolled, whichever comes first, unless a shorter period is required by law
  - I agree that if I reside in the state of Maryland, this form will be valid for no longer than 1 year from the date I signed
  - I have the right to cancel this authorization. If I cancel, this means that Genentech and/or the Genentech Patient Foundation will no longer use or share my PII, but this will not apply to PII already used or shared or when it is required by law. If I reside in California, I also have the right to request that Genentech and/or the Genentech Patient Foundation delete my PII, although deletion is not required under certain circumstances. To cancel or request deletion, I must send a written notice to Genentech. It can be sent by fax or by mail to the address below. If I cancel and request deletion, I know that Genentech and the Genentech Patient Foundation will no longer be able to assist me with access to my Genentech products. The address is Genentech, 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990
- I understand that I, as the patient or signer, have a right to receive a copy of this signed form over the time it is valid.

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Required field (\*)

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

\*First name: \_\_\_\_\_ \*Last name: \_\_\_\_\_

Home phone†: (\_\_\_\_\_) - \_\_\_\_\_ Cell phone†: (\_\_\_\_\_) - \_\_\_\_\_

☐ OK to leave a detailed message? ☐ OK to send a text message? Date of birth (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Email: \_\_\_\_\_ Preferred language: ☐ English ☐ Spanish ☐ Other: \_\_\_\_\_

Alternate Contact (optional) Full name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone†: (\_\_\_\_\_) - \_\_\_\_\_

1

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

REQUIRED

Sign and  
date here

\_\_\_\_\_  
\*Signature of Patient/Authorized Person

\_\_\_\_\_  
\*Date signed

(A parent or guardian must sign for patients under 18 years of age)

(MM/DD/YYYY)

Person signing  
(if not patient)

\_\_\_\_\_  
Print first name

\_\_\_\_\_  
Print last name

\_\_\_\_\_  
Relationship to patient

2

### 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 1.

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

Sign and date here

\_\_\_\_\_  
Signature of Patient/Authorized Person

\_\_\_\_\_  
Date signed

(A parent or guardian must sign for patients under 18 years of age)

(MM/DD/YYYY)

3

Patient consent to enroll in optional disease-specific education, support programs, market research and communications offered by Genentech USA, Inc., its partners, and their respective affiliates ("Sponsors") that may be considered marketing. I understand my PII may be needed by Sponsors for me to participate in these programs.

Sign and date here  
to choose to enroll

\_\_\_\_\_  
Signature of Patient/Authorized Person

\_\_\_\_\_  
Date signed

(A parent or guardian must sign for patients under 18 years of age)

(MM/DD/YYYY)

†By providing my phone number and signing Box 3, I authorize Genentech USA, Inc., its partners, and their respective affiliates ("Sponsors") to use auto-dialers or prerecorded and artificial voice to contact me. I understand that these calls/texts may mention the name of Genentech or Sponsors' jointly-marketed 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 enrollment or of the purchase of any Genentech or Sponsors' jointly-marketed products or services. 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).

Once this page (3/3) has been completed, please text a photo of the page to (650) 877-1111, or fax to (866) 480-7762. You can also complete this form online at [Genentech-Access.com/PatientConsent](https://www.genentech-access.com/PatientConsent).

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