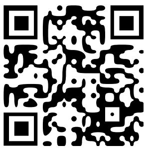
Genentech
A Member of the Roche Group
Access Solutions

for PiaSky™ (crovalimab-akkz)

Prescriber Service Form

SUBMIT ONLY REQUESTED DOCUMENTS

Complete online by scanning QR code or visit **Quick Enroll (QE)**



Required field (*) M-US-00023541(v1.0)

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
Email: ______ Preferred language: ☐ English ☐ Spanish ☐ Other: ______
Alternate contact name: ______ Relationship: ______ Alt. phone: ( ) -

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	Pharmacy Benefit
Insurance name			
Subscriber name (if not patient)			
Subscriber/Policy ID #			
Group #			
Insurance phone			

☐ By checking this box, I am requesting a benefits investigation on the meningococcal vaccine.

3 Dosing Regimen and Prescription Information

*DOSING REGIMEN (Please select appropriate weight-based regimen.)

Body Weight		☐ ≥40 to <100 kg	☐ ≥100 kg
Loading Doses	Day 1	1,000 mg (IV)	1,500 mg (IV)
	Day 2, 8, 15, 22	340 mg (SC)	340 mg (SC)
Maintenance Doses	Day 29 and Q4W thereafter	680 mg (SC)	1,020 mg (SC)

*PRESCRIPTION INFORMATION

Patient weight: ______ kgs

Refills: ______

4 Diagnosis and Clinical Information (Complete to the highest level of specificity for diagnosis codes.)

*Primary diagnosis code: ______

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: ( ) -

If you are a resident of a US state that provides certain rights with respect to your personal information, a complete description of the personal information we may collect and process, the purposes for which it is used by Genentech, and your rights under your state's privacy laws concerning your personal information can be found in our privacy notice at **www.gene.com/privacy-policy**.

6 Day 1 IV Loading Dose

Place of Administration: ☐ Physician's office ☐ HOPD ☐ Infusion center ☐ Other (please specify): ______
Name: ______ Tax ID #: ______ NPI #: ______

7 PiaSky Co-pay Assistance Program Enrollment

☐ By checking this box, I certify that:

- I have the patient's consent to enroll in the Genentech PiaSky Co-pay Assistance Program for assistance with drug out-of-pocket costs
- The patient is not using and I will not bill any federal or state-funded health care program. This includes, but is not limited to, Medicare, Medicaid, Medigap, VA, DoD and TRICARE
- The patient is not currently receiving Genentech PiaSky from the Genentech Patient Foundation
- The patient is not currently receiving assistance from any other charitable organization for any of their out-of-pocket costs that are covered by the Genentech PiaSky Co-pay Assistance Program
- Genentech reserves the right to rescind, revoke or amend the program without notice at any time
- I have read and accepted the full Program Terms and Conditions as found on the following link: **www.genentech-access.com/piasky/co-pay-terms-conditions**

8 Health Care Provider Certification

BY SUBMITTING THIS FORM:

I am requesting services on behalf of the patient, which may include benefits investigation and reverification, help navigating the PA process and appeals support.

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

DoD=US Department of Defense; FDA=US Food and Drug Administration; HOPD=hospital outpatient department; IV=intravenous; NPI=National Provider Identifier; Q4W=every four weeks; SC=subcutaneous; VA=Veterans Affairs.

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