INSTRUCTIONS: HOW TO COMPLETE THE AVASTIN PATIENT ASSISTANCE PROGRAM ENROLLMENT FORM

Phone: (888) 249-4918
Fax: (888) 249-4919
www.AvastinAccessSolutions.com

Enrollment Requirements

- Complete the Enrollment Form and a signed and dated Patient Authorization and Notice of Release of Information (PAN) form
- Please attach infusion records for Avastin® (bevacizumab) treatment
- Fax both forms plus the infusion record to Avastin® Access Solutions™
  - — Avastin Access Solutions cannot enroll the patient without a signed and dated PAN form

Physician Profile

- Your DEA and Medical License numbers are required in order for you to receive shipments of Avastin

Patient Financial Information

- The Avastin Patient Assistance Program is open to all patients receiving Avastin with a household adjusted gross income of up to $100,000
- Please check the appropriate box to indicate the patient's household adjusted gross income (can be obtained from the patient's Internal Revenue Service form 1040 U.S. Individual Income Tax Return, line 37)
- This information is required in order to determine if the patient meets the financial criteria
- The patient is required to sign and date this section of the form

Patient Insurance Information

- The Avastin Patient Assistance Program is open to all patients receiving Avastin, regardless of insurance coverage
- Please check the appropriate box to indicate patient's insurance status

Diagnosis

- An ICD-9 code is required in order to determine if the patient meets the medical criteria
- Only patients being treated for FDA-approved indications are eligible for the Avastin Patient Assistance Program

Prescription/Regimen

- Recommended dosage of Avastin:
  - — For first- or second-line treatment of metastatic colorectal cancer (MCRC):
    - Treatment of MCRC in combination with IFL: 5 mg/kg q2w
    - Treatment of MCRC in combination with FOLFOX4: 10 mg/kg q2w
  - — First-line treatment of unresectable, locally advanced, recurrent or metastatic non-squamous, non-small cell lung cancer (in combination with carboplatin and paclitaxel): 15 mg/kg q3w
- To convert patient's weight into kilograms, divide weight in pounds by 2.2
- Please check appropriate clinical/TNM stage and line of therapy — these are required for eligibility

Shipping Instructions

- Check the box if your shipping address is the same as the address listed in the Physician Profile section
- If address is different, please list it in the space provided

REMINDER: This form cannot be processed without a physician's signature and date as well as a signed and dated PAN form.

AVASTIN® bevacizumab Access Solutions™ Treatment made possible.™

Genentech BIOONCOLOGY™

Avastin Patient Assistance Program
Patient Enrollment Form
Phone: (888) 249-4918 Fax: (888) 249-4919
www.AvastinAccessSolutions.com

AVASTIN® bevacizumab

Access Solutions™
Treatment made possible.™

Please complete the information below and fax this form, with the Patient Authorization and Notice of Release of Information form and infusion records for Avastin® (bevacizumab) treatment, to Avastin® Access Solutions™ for enrollment in the Avastin Patient Assistance Program.

Patient Information

Name (First and Last): _____
☐ Male ☐ Female
Street: _____
City: _____ State: _____ ZIP: _____
Date of Birth (MM/DD/YY): _____
Home Phone: ( ) _____
Work/Cell: ( ) _____
Is it okay to contact the patient? ☐ Yes ☐ No

Physician Profile

Facility/Group Name: _____
Physician's Full Name: _____
DEA #: _____ Medical License #: _____
Office Hours: _____
Street: _____
_____
City: _____ State: _____ ZIP: _____
Phone: ( ) _____
Fax: ( ) _____
Contact Person: _____
Phone: ( ) _____

Patient Financial Information

I understand that in order to qualify, my adjusted gross income may not exceed $100K/yr. I certify that my household's adjusted gross income is accurately represented below. If requested, I understand that I will be responsible for providing written documentation supporting this certification.

Household Adjusted Gross Income:
☐ $0-25K/yr ☐ $25,001-50K/yr
☐ $50,001-75K/yr ☐ $75,001-100K/yr

Patient Signature (required): _____
Date (required): _____

Patient Insurance Information

Check All That Apply
☐ Commercial/Private (name): _____
☐ Medicare With Supplemental ☐ VA/Tricare
☐ Medicare Without Supplemental ☐ Uninsured
☐ Other (please specify): _____

Please note: Insurance status will not affect patient eligibility.

Diagnosis

Primary ICD-9 Code: _____ Description: _____

Prescription/Regimen

Date of first Avastin treatment in current course: _____
Total # of Avastin infusions received to date in current course: _____
Anticipated date of next Avastin infusion: _____
Frequency of administration: _____
Dose: ____ mg/kg Patient's weight: _____ kg
Clinical/TNM stage: ☐ IIIB ☐ IIIC ☐ IV
Line of therapy: ☐ First ☐ Second
Place of Avastin administration: ☐ Physician office ☐ Hospital outpatient
☐ Hospital inpatient ☐ Other (please specify): _____

Shipping Instructions

☐ Same address as physician profile
Name of Facility/Practice: _____
Street: _____
City: _____ State: _____ ZIP: _____
Phone: ( ) _____

- I certify that I am prescribing Avastin for this patient in a manner that is consistent with the FDA-approved labeling for use in the treatment of a disease or other recognized medical condition
- I further certify that the information provided on this form is true and that the medication received in response to the submission will be used to treat the patient described
- I agree with the program guidelines as established by Genentech, and I will not bill any federal, state or private payer for Avastin provided to me in connection with the program
- I will provide infusion records as proof that Avastin vials received in connection with the program were used to treat the above-named patient
- I will notify Avastin Access Solutions immediately if the above-referenced patient ceases to be in my care
- I certify that all of the Avastin that will be counted toward the threshold was administered by a single provider organization, and any free product provided will be administered by the same provider organization
- The patient has consented, in writing, to the release of information contained herein and attached

Physician Signature: _____

Date: _____

Original Signature Required - Stamped Signature Will Not Be Accepted.

Please review this form carefully. The Avastin Patient Assistance Program will not be able to provide product if information is missing.

The Avastin Patient Assistance Program at its sole and absolute discretion reserves the right to verify the accuracy of the information submitted and modify or discontinue the program at any time.

The Avastin Patient Assistance Program is for patients with FDA-approved indications. The current FDA-approved indications are: Avastin, in combination with intravenous 5-fluorouracil–based chemotherapy, is indicated for first- or second-line treatment of patients with metastatic carcinoma of the colon or rectum. Avastin, in combination with carboplatin and paclitaxel, is indicated for first-line treatment of patients with unresectable, locally advanced, recurrent or metastatic non-squamous, non-small cell lung cancer.

Confidentiality Notice: This facsimile transmission contains information for Avastin Access Solutions that is confidential or privileged. This information is intended for the individual or entity named on this transmission sheet. If you are not the intended recipient, be aware that the disclosure, copying, distribution or use of the contents of this faxed information is strictly prohibited.

8981100

Genentech
BIOONCOLOGY™

Patient Authorization and Notice of Release of Information

Genentech BioOncology Access Solutions™ Treatment made possible.™

Dear Patient:

Genentech BioOncology Access Solutions is a program sponsored by Genentech USA, Inc. that provides support services such as benefits investigations, prior authorizations and appeals assistance at no charge to patients, and assists them in obtaining reimbursement for Genentech products. If a patient does not have insurance or is deemed uninsured due to denial by private and public payers, and the patient meets certain financial and medical criteria, the Genentech® Access to Care Foundation may provide Genentech products free of charge. Additional information on these programs can be found on www.BioOncologyAccessSolutions.com.

In order for Genentech BioOncology Access Solutions and Genentech Access to Care Foundation to provide the described services, we will need to review, use and disclose your protected health information (PHI). By law, only with your prior written authorization may your health care provider, health plan or health insurer disclose your PHI to Genentech BioOncology Access Solutions and Genentech Access to Care Foundation. As soon as we obtain your prior written authorization, we will work to provide you the services.

You are not required to agree to this Authorization. However, failure to provide this Authorization may prevent you from becoming eligible for the Genentech BioOncology Access Solutions coverage and reimbursement assistance or Genentech Access to Care Foundation patient assistance programs, which may result in your need to pay for certain products with your own funds. You will receive a copy of the Authorization you sign.

Please review this Authorization carefully. If you have any questions regarding this Authorization, please contact your health care provider's office. Contact information is included below.

AUTHORIZATION

I. Information to Be Disclosed or Used

This Authorization permits my health care providers, health plans and health insurers who provide services to me to use and disclose to Genentech BioOncology Access Solutions or Genentech Access to Care Foundation and, its authorized agents and assignees, all medical records and financial information with respect to my treatment, which may have bearing on the benefits payable for services or products provided through my health care provider, health plan or insurer under any plan providing benefits or services, including, without limitation, the dollar balance of benefits remaining under any applicable lifetime maximum benefits provisions, or which may have a bearing on my medical condition or compliance with therapy. All of this information may be considered PHI, and may, if relevant, include information about HIV/AIDS and/or other communicable diseases, mental health information, and/or information concerning genetic test results.

II. Persons Authorized to Disclose Information

The PHI identified in Paragraph I may be disclosed by my health care provider, health plan, health insurer or others who may hold my PHI.

www.BioOncologyAccessSolutions.com
Phone: (888) 249-4918 Fax: (888) 249-4919

III. Persons to Whom Disclosure May Be Made

The PHI identified in Paragraph 1 may be disclosed to and/or used by Genentech BioOncology Access Solutions or Genentech Access to Care Foundation, their sponsor Genentech USA, Inc., a biopharmaceutical manufacturer located at 1 DNA Way, Mail Stop #210, South San Francisco, CA 94080, and its related entities, their agents or assignees, certain Genentech business partners (such as Biogen Idec, Inc. and OSI Pharmaceuticals, Inc.), the Centers for Medicare & Medicaid Services, as well as other companies involved in the administration of certain Genentech products.

IV. Description of Each Purpose

My PHI may be used for the purposes of reimbursement and/or participation in a coverage and reimbursement assistance or patient assistance program administered by Genentech BioOncology Access Solutions and Genentech Access to Care Foundation, respectively. My PHI may also be used for purposes of tracking the general use of a Genentech product, assessing and improving Genentech's coverage and reimbursement and patient assistance services, and proper management and administration of Genentech's business.

V. Expiration Date or Event

California residents only: This Authorization will be effective, unless revoked by me in writing until December 31, 2015.

All other residents: This Authorization will be effective, unless revoked by me in writing, for up to one year from the date of this Authorization.

VI. Notices

I understand that once my health information is disclosed pursuant to this Authorization, there is no guarantee under federal law that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my health care provider's treatment of me. If I refuse to sign or revoke this Authorization, however, I may be responsible for costs that may have otherwise been covered by Genentech BioOncology Access Solutions or Genentech Access to Care Foundation.

I understand that this Authorization will remain in effect until it expires as described above or I provide a written notice of revocation via mail to Genentech BioOncology Access Solutions, 1 DNA Way, Mail Stop #210, South San Francisco, CA 94080 or via fax to (888) 249-4919. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider or others referenced in this Authorization, including without limitation, Genentech BioOncology Access Solutions or Genentech Access to Care Foundation, in reliance on this Authorization before my health care provider received my written notice of revocation.

Patient Authorization and Notice of Release of Information

Genentech BIOONCOLOGY™ Access Solutions™ Treatment made possible.™

VII. Distribution Acknowledgment

I hereby state (or my parent/guardian hereby states) that if I should receive free product from Genentech Access to Care Foundation, I will utilize it for the reason that my physician has prescribed it to me. I will not sell or distribute a Genentech BioOncology product, as I acknowledge it is unlawful to do so. I will be responsible to ensure that any Genentech BioOncology product being delivered to me will be delivered to a secure address for purposes of receipt of shipment and I understand it is my duty to control any Genentech BioOncology product while it remains in my possession.

VIII. Signature

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the use and/or disclosure of my health information in the manner described above.

REQUIRED

Print Patient's Name

Signature of Patient or Guardian* Date

*If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally)

Description of Authority

Patient's/Guardian's Address

OPTIONAL

CANCER CONNECTIONS Free Patient Support Program

I authorize Genentech USA, Inc. to enroll me in *Cancer Connections,* a free personalized patient support program. I understand that my name, address, e-mail address and phone number, once provided by me, will by sent by Genentech BioOncology Access Solutions to *Cancer Connections* to complete my enrollment. I agree that Genentech and its agents may contact me in the future by mail, e-mail, and/or telephone concerning the *Cancer Connections* program. I understand that all personally identifiable information will be kept strictly confidential and will not be distributed outside of Genentech or its agents, as the Genentech USA, Inc. privacy policy provides (available at www.cancerconnections.com). I also understand that I do not have to sign this authorization in order to receive Genentech BioOncology products or participate in the Genentech BioOncology Access Solutions/ Genentech Access to Care Foundation programs and that I may cancel this authorization at any time by giving written notice to Genentech USA, Inc. through its agent at PO Box 29284, Shawnee Mission, KS 66201-9919.

Signature of Patient Patient's Email Address Date

www.BioOncologyAccessSolutions.com
Phone: (888) 249-4918 Fax: (888) 249-4919

Fax: (888) 249-4919
www.BioOncologyAccessSolutions.com
FAX COVER SHEET

Attn: Avastin Patient Assistance program	**Date:**
To:	**Fax #:** (888) 249-4919
From:	**Phone:**
	# Pages:

Patient's Name:	Date of Birth:

Check the applicable box(es) below:

- ☐ New Patient Referral
- ☐ Infusion records attached
- ☐ Next infusion date: _____, please coordinate shipment
- ☐ Other (explanation written below)