

## **Patient Authorization and Notice of Request** for Transmission of Health Information to Nutropin GPS™ and Genentech® Access to Care Foundation (PAN)

**Phone:** (866) 688-7674 **Fax:** (800) 545-0612

**Nutropingps.com**

ACS/013117/0027 03/17

### **Nutropin GPS is a free program for you from Genentech.**

Nutropin GPS (Growing Patient Support) works to help you understand how to pay for your Genentech product. We assist people who have a health care plan as well as those who don't.

If you don't have a health care plan, or your plan won't pay for your Genentech products, Genentech might be able to help. If you meet certain criteria, we can supply free medicine. This is done through the Genentech Access to Care Foundation (GATCF).

Nutropin GPS and GATCF take patient privacy seriously. We recognize that your health information is sensitive and take steps to protect it and keep it confidential. In order for Nutropin GPS to help you, we will need to look at, use, and disclose some of your personally identifiable information (PII) including health information. By signing this form, you are directing your health care provider and health care plan to transmit certain PII to us and you are authorizing us to use and further disclose your PII as necessary to assist you. Once you sign this form and it is sent back to us, or it is submitted electronically by you or your health care provider on your behalf, we can start assisting you. You can choose not to sign this form; however, please note that we cannot assist you without it.

### **Please read through this form carefully.**

If you have any questions, talk to your health care provider's office or call us at the phone number listed at the top of this page.

### **1 Information that may be used or disclosed**

I am directing my health care provider(s) and/or health care plan(s) to share the following information with Nutropin GPS and/or GATCF:

- Health information related to my treatment with Genentech products, including relevant diagnoses and prescriptions
- Information about my health care plan benefits, including my deductibles and anticipated annual and lifetime out-of-pocket costs

## 2 Who may see and use my PII

I authorize Nutropin GPSTM and/or GATCF to use and further disclose my PII to Agents, affiliates and vendors who are assisting Nutropin GPS and/or GATCF; and my health care provider(s), health care entities, pharmacies and health plan(s) for the purpose of facilitating my access to Genentech products, including:

- Coordinating with my health care plan for understanding coverage for Genentech products
- Applying to GATCF
- Determining my eligibility for alternative forms of coverage and sources of funding for my Genentech medicines
- Coordinating fulfillment of my prescription through a pharmacy
- For administrative purposes that support Nutropin GPS and GATCF

## 3 Notices

This PAN shall be in effect for 3 years from the date of my signature, or the date of last enrollment, whichever comes first, unless a shorter period is required by law.

**I understand that if I am a resident of the state of Maryland, this authorization will be valid for no longer than 1 year from the date I signed it.**

Once I sign this PAN form and my PII is transmitted to Nutropin GPS and/or GATCF, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect the PII disclosed to Nutropin GPS and/or GATCF by my health care provider or others covered by the HIPAA laws because Nutropin GPS and GATCF are not covered by HIPAA. I understand that Nutropin GPS and GATCF 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 understand that I can refuse to sign this PAN form. I also understand that I can cancel this PAN form at any time and for any reason. I understand that this cancellation means that Nutropin GPS and/or GATCF will no longer use or share my PII, but does not apply to PII already used or shared. To cancel this PAN form, I must send a written notice to Genentech. It can be sent by fax or by mail to the address on this page. If I cancel this PAN form, I understand that Nutropin GPS and GATCF will no longer be able to assist me with access to my Genentech product(s).

The address for Nutropin GPS and GATCF is PO Box 220039, Charlotte, NC 28222-0039. The fax number for Nutropin GPS and GATCF is (800) 545-0612.

I understand that I, as the patient or signer, have a right to obtain a copy of this signed PAN form during the period it is in effect.

## 4 Distribution acceptance

If I receive free product from GATCF, I will not sell or distribute Genentech products. I understand it is unlawful to do this. I am responsible for ensuring any Genentech product is sent to a secure address when it is shipped to me. I know it is my duty to control any Genentech product while it stays in my possession.

**Section 5 on the next page is required.**  
This written notice must be signed, dated, and mailed, faxed or electronically submitted to:

Nutropin GPS  
PO Box 220039, Charlotte, NC 28222-0039  
Fax: (800) 545-0612

## 5 Signature and date

(Required in order to obtain the assistance of Nutropin GPS™ and the Genentech® Access to Care Foundation)\*

Please fill in all information below. Be sure to sign and date this form. If you don't, it could hold up the process for helping you.

### Required:

### Optional:

Print patient name

\_\_\_\_\_  
Last Name First Name Date of Birth

\_\_\_\_\_  
Signature of Patient/Legally Authorized Person Date Signed

Print name of person signing (if not the patient)

\_\_\_\_\_  
Last Name First Name Relationship to Patient

**OK to leave a detailed message†:**

I authorize Nutropin GPS/GATCF to leave a detailed message at the following number:  
  
\_\_\_\_\_

\*If an error is made, the person signing the PAN form must correct the information by putting a single line through the mistake and initialing it. Rewrite the correct information next to the mistake. Other forms of correction, such as crossing out words or white-out will not be accepted.

†By providing my phone number, I authorize Genentech to use auto-dialers, prerecorded messages, and artificial voice messages to contact me. I understand that these calls/texts may mention the name of Genentech 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 any purchase of Genentech products or enrollment in Nutropin GPS or GATCF.

## 6 Financial information (GATCF only)

Total household income for the previous calendar year: \$ \_\_\_\_\_

**Read the following attestation:** I understand that to qualify for free medicine, GATCF has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage to pay for Genentech products. I know that GATCF could ask me for a copy of my IRS 1040 form or other proof of income for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify GATCF immediately if my insurance situation changes. Please note that GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge.

Choose to enroll by signing and dating here

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

\_\_\_\_\_  
Date Signed

## 7 Genentech marketing consent

I want to enroll in optional and free programs sponsored by Genentech, related to the use of Genentech products. These programs may include co-pay assistance, other patient support programs, providing me with information or marketing materials about other products or services available from Genentech and its affiliates, or opportunities to participate in surveys or provide feedback. I understand my personally identifiable information (PII), including information about my use of Genentech products, may be needed for me to be a part of these programs. I understand by enrolling in these programs, Genentech may share information concerning my health with those who are responsible for administering these programs. I may choose to be contacted by mail, email, phone and/or text message. I understand the use and disclosure of my PII will be limited to Genentech, its successors, and its Agents, except as required by law. I agree to let Genentech, its successors, or its Agents contact me in the future about these programs.

I understand the following:

- This consent to enroll in these programs or receive marketing information is voluntary,
- I can get assistance from Nutropin GPS™ even if I do not sign this consent,
- I can get my medicine even if I do not sign this consent, and
- I may cancel my enrollment or consent to marketing at any time.

To cancel, I can call (877) 436-3683 toll free.

### Preferred way to contact me

(Please check all boxes that apply.)

- Email: \_\_\_\_\_
- Phone number (voice message): \_\_\_\_\_ OK to leave a message?  Yes  No
- Phone number (text message): \_\_\_\_\_

By checking one or more of the above boxes to receive voice messages and/or text messages, I authorize Genentech to use auto-dialers, prerecorded messages and artificial voice messages to contact me. I understand that these voice calls and text messages may market or advertise Genentech products, goods or services. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of goods or services.

- Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Choose to enroll  
by signing  
and dating here

\_\_\_\_\_  
Signature of Patient/Legally Authorized Person  
(You must sign here to enroll in the programs related to Genentech products as described above.)

\_\_\_\_\_  
Date Signed

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**Genentech**  
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