

STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all required fields (*) to prevent delays.

Phone: (888) 587-9438 Fax: (866) 827-8188 BonivaReimbursement.com



SERVICES REQUESTED* (check all that apply)

Benefits Investigation/Prior Authorization

Appeals Support

GATCF[†] Patient Assistance

PATIENT

Last name*: _____ First name*: _____ Birth date*: _____ Gender*: Male Female
Street: _____ City: _____ State*: _____ ZIP: _____
Home phone: (_____) _____ Work/cell phone: (_____) _____ Email: _____
Alternate contact last name: _____ First name: _____ Phone: (_____) _____
Relationship to patient: _____ OK to contact patient? Yes No

INSURANCE

| | | | |
|---|------------------------------|---|---------------------------------------|
| <input type="checkbox"/> HMO/EPO | <input type="checkbox"/> PPO | <input type="checkbox"/> POS | <input type="checkbox"/> Indemnity |
| <input type="checkbox"/> Medicare/Medicaid | <input type="checkbox"/> PBM | <input type="checkbox"/> Pending Medicaid | <input type="checkbox"/> No insurance |
| Insurance denial/non-coverage policy attached? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Primary insurance (PI) name: _____ | | | |
| PI phone: _____ | | | |
| PI subscriber name: _____ | | | |
| PI subscriber ID #: _____ | | | |
| Policy/group #: _____ | | | |
| Insurance card attached? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| | | | |
|---|------------------------------|---|---------------------------------------|
| <input type="checkbox"/> HMO/EPO | <input type="checkbox"/> PPO | <input type="checkbox"/> POS | <input type="checkbox"/> Indemnity |
| <input type="checkbox"/> Medicare/Medicaid | <input type="checkbox"/> PBM | <input type="checkbox"/> Pending Medicaid | <input type="checkbox"/> No insurance |
| Insurance denial/non-coverage policy attached? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Secondary insurance (SI) name: _____ | | | |
| SI phone: _____ | | | |
| SI subscriber name: _____ | | | |
| SI subscriber ID #: _____ | | | |
| Policy/group #: _____ | | | |
| Insurance card attached? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

DIAGNOSIS/TREATMENT

DIAGNOSIS (highest level of specificity)*: Senile (Postmenopausal) Osteoporosis (733.01) Other: Specify by ICD-9: _____
Has patient started prescribed therapy? Yes No If so, last treatment date: _____
Medical rationale for prescribing medication: _____
 NKDA or Allergies: _____

INFUSION/ACQUISITION

SPECIALTY PHARMACY NEEDED FOR BONIVA® (ibandronate sodium) DISPENSING? Yes No (MD's office will supply)
Preferred specialty pharmacy: _____
PLACE OF INJECTION: Prescribing physician's office Other physician's office Hospital outpatient Other: _____
Injection site tax ID #: _____ Injection site NPI[‡] #: _____
Street: _____ City: _____ State: _____ ZIP: _____
Contact name: _____ Phone: (_____) _____

PRESCRIPTION

| | | | |
|-------------|--|------------------|--|
| ORAL | <input type="checkbox"/> BONIVA ORAL Dispense: <input type="checkbox"/> 150 mg <input type="checkbox"/> 30-day supply <input type="checkbox"/> 60-day supply <input type="checkbox"/> 90-day supply Refill _____ times SIG: <input type="checkbox"/> Take one tablet once a month with a full glass of water. Remain upright and do not eat for 60 minutes <input type="checkbox"/> Other: _____ | INJECTION | <input type="checkbox"/> BONIVA INJECTION Dispense: <input type="checkbox"/> 3 mg/mL <input type="checkbox"/> 90-day supply Refill _____ times SIG: <input type="checkbox"/> Inject into a vein over 30 seconds once every 3 months <input type="checkbox"/> Other: _____ |
|-------------|--|------------------|--|

PRESCRIBER

Prescriber's last name*: _____ First name*: _____
Practice name: _____ Specialty: _____
Street*: _____ City*: _____ State*: _____ ZIP*: _____
Phone: (_____) _____ Fax: (_____) _____
Prescriber Tax ID: _____ Prescriber NPI: _____
DEA #: _____ Group NPI: _____ State license #: _____ PTAN[§]: _____
Reimbursement/clinical contact last name: _____ First name: _____
Reimbursement/clinical contact phone: (_____) _____ Fax: (_____) _____

UNAPPROVED USE WARNING: Please read the FDA-approved labels for Boniva before prescribing. If the indication for which you are prescribing Boniva is not listed in the label, you are prescribing Boniva for an "unapproved" use. The fact that the use for which you are prescribing Boniva is not listed in the FDA-approved label indicates that the FDA has not approved the efficacy, dosage amount or safety of Boniva when used for such a use. Nevertheless, GATCF will consider providing Boniva for your patient with this admonition, based upon your medical order, within program requirements.

By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) to Genentech, Inc., Boniva Reimbursement, GATCF and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for GATCF related to Genentech products, as a break in treatment would negatively impact the patient's therapeutic outcome, (c) I will not attempt to seek reimbursement for free or replacement product provided directly to the patient or for the dates of service for which free or replacement product was provided and (d) I appoint Boniva Reimbursement solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein.

I agree to comply with the program guidelines as established by Genentech, Inc. and understand that GATCF, at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted. I further understand that Genentech will provide vial replacement in a configuration that will create the least amount of wastage.

Prescriber's Signature* _____ Date* _____
(Original signature required. This form cannot be processed without a prescriber's signature.)

* Required field. [†]Genentech® Access to Care Foundation. [‡]National Provider Identifier. [§]Provider Transaction Access Number.

STATEMENT OF MEDICAL NECESSITY (SMN)

Please write legibly and complete all sections to prevent delays.

SERVICES REQUESTED

- Check the appropriate services requested. Boniva Reimbursement and/or GATCF cannot perform services without your specific authorization

INSURANCE INFORMATION

- If the patient is insured, provide a front and back copy of the patient's drug card

DIAGNOSIS/TREATMENT

- Check the appropriate Diagnosis Code
- If "Other" is checked, specify the ICD-9 code to the highest level of specificity using the 3-, 4- or 5-digit code

INJECTION AND DRUG ACQUISITION INFORMATION

- Check the appropriate box to indicate the need for a specialty pharmacy to dispense Boniva® (ibandronate sodium) injection, or you would like to use an alternate site of injection. Boniva Reimbursement will verify with your patient's insurance plan whether a specialty pharmacy or other injection site is in network
- Complete according to the planned (patient has not yet received Boniva) or administered (patient has already been injected with Boniva) dosing

MEDICAL RATIONALE FOR PRESCRIBING BONIVA MAY INCLUDE

- Lack of response to standard therapies
- Unacceptable side effects of prior treatments
- Treatments that are difficult to use and those to which adherence is an issue
- Exhaustion of available therapies (if applicable)
- Symptoms and impact on daily life
- Other rationale

PRESCRIPTION

Please indicate the prescribed therapy (Boniva Oral or Injection)

- Complete the dose and refill fields only if you are planning to use a specialty pharmacy to acquire Boniva for your patient, or if you are requesting GATCF assistance for your patient

PRESCRIBER

- Stamped prescription signatures are not accepted

GATCF REQUIRED FIELDS

- All GATCF required fields are indicated with an asterisk (*)
- GATCF cannot process your SMN unless these fields are completed

ATTACH TO COMPLETED SMN

- Attach a signed and dated Patient Authorization and Notice of Release of Information (PAN) form. Boniva Reimbursement and/or GATCF cannot work with the insurance plan on your patient's behalf without a signed and dated PAN form

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

BonivaReimbursement.com

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Boniva® is a registered trademark of Genentech, Inc.

