www.needymeds.org

Find help with the cost of medicine

Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Healthcare Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.

Rich Sagall, MD
President, NeedyMeds

Clip the card and save

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

STATEMENT OF MEDICAL NECESSITY (SMN)

CellCept® (mycophenolate mofetil)

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

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Phone: (888) 754-7651   Fax: (800) 305-1830

M-US-00001754(v2.0) 6/21

SERVICES REQUESTED* (check only those that apply)
☐ GATCF[†] Patient Assistance   ☐ Co-pay 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 Pt. preferred language (if other than English): ____

INSURANCE

☐ HMO/EPO ☐ PPO ☐ POS ☐ Indemnity
☐ Medicare/Medicaid ☐ PBM ☐ Other: ____
☐ No insurance

Insurance denial/non-coverage policy attached? ☐ Yes ☐ No

Primary insurance (PI) name: ____
PI phone: ____
PI subscriber name: ____
PI subscriber ID #: ____
Policy/group #: ____
Insurance card attached? ☐ Yes ☐ No

☐ HMO/EPO ☐ PPO ☐ POS ☐ Indemnity
☐ Medicare/Medicaid ☐ PBM ☐ Other: ____
☐ No insurance

Insurance denial/non-coverage policy attached? ☐ Yes ☐ No

Secondary insurance (SI) name: ____
SI phone: ____
SI subscriber name: ____
SI subscriber ID #: ____
Policy/group #: ____
Insurance card attached? ☐ Yes ☐ No

DIAGNOSIS/TREATMENT

DIAGNOSIS CODE (indicate code type and complete to highest level of specificity)*: ____
Has patient received transplant? ☐ Yes ☐ No Date of scheduled/performed transplant: ____
Transplant paid by Medicare? ☐ Yes ☐ No
Has patient started prescribed therapy? ☐ Yes ☐ No If so, last treatment date: ____
☐ NKDA or ☐ Allergies: ____

CONTACT & SHIPPING

IS PATIENT CURRENTLY IN A HOSPITAL AWAITING A TRANSPLANT? ☐ Yes ☐ No
Transplant coordinator name: ____ Phone: (____) ____
PRIMARY CONTACT: ☐ Transplant coordinator ☐ Physician (see PRESCRIBER section for contact information)
Please send this supply of medication to: *(If not indicated, medication will ship to the patient's address.)*
☐ Patient address ☐ Prescriber address ☐ Hospital/other address: ____
Specialty pharmacy needed for dispensing? ☐ Yes ☐ No (Local retail or mail order pharmacy to be used)
Preferred specialty pharmacy: ____

PRESCRIPTION

DISPENSE CELLCEPT® (MYCOPHENOLATE MOFETIL) (CHECK 1 BOX IN EACH COLUMN):

☐ 250-mg capsules	☐ BID	☐ 30-day supply ☐ 90-day supply	Refill ____ times
☐ 500-mg tablets	☐ Other	☐ 60-day supply ☐ Other: ____	
☐ 200-mg/mL oral suspension			

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

By signing below, I am agreeing to the following:

(A) The Genentech medicine listed above is medically necessary for this patient. (B) I have received authorization to release the information above and other protected health information (as defined by HIPAA) to the Genentech Access to Care Foundation and its affiliates. (C) I will not seek reimbursement for free product provided to the patient. (D) My patient meets the criteria for the Genentech Access to Care Foundation. (E) I understand that Genentech reserves the right to modify or discontinue the program at any time and to verify the accuracy of information submitted. (F) For insured patients, I understand that the Genentech Access to Care Foundation does not provide free drug in the instance of an administrative error or a coverage restriction such as a step edit. For certain products where the step edit may not be medically appropriate, as confirmed by the prescribing physician, the Genentech Access to Care Foundation may consider support following 1 level of appeal. (G) For prescribers in states with official prescription form requirements, such as New York, prescriptions must be submitted on an official state prescription pad along with this enrollment form.

Sign and date here

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.

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STATEMENT OF MEDICAL NECESSITY (SMN)

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

SERVICES REQUESTED

- Check the appropriate services requested on behalf of the patient. GATCF cannot perform services without your specific

DIAGNOSIS/TREATMENT

- Enter the appropriate Diagnosis Code to the highest level of specificity using the appropriate 3-, 4-, 5- or 6-digit code

CONTACT AND SHIPPING

- If patient is awaiting transplant, please indicate the transplant coordinator contact information
- Identify the primary contact (transplant coordinator or physician)

PRESCRIPTION

- Complete the dose and refill fields along with the dispense instructions

PRESCRIBER

- Stamped prescription signatures are not accepted

GATCF REQUIRED FIELDS

- All 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 Request for Transmission of Health Information (PAN) form to Genentech Access Solutions and GATCF. GATCF cannot work on your patient's behalf without a signed and dated PAN form

PROVIDING ADDITIONAL DOCUMENTS OR INFORMATION WITH THIS FORM, OTHER THAN WHAT IS REQUESTED, WILL DELAY PROCESSING.

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

Phone: **(888) 754-7651** **Fax:** **(800) 305-1830**

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