# Genentech Co-pay Program

## Provider Portal User Guide

Genentech
*A Member of the Roche Group*

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This is an overview of the Genentech Co-pay Program benefits and online claims portal. The co-pay program is intended to assist your patients in gaining access to, and remaining on, their prescribed Genentech treatment.

## PROGRAM FEATURES

- Patients are automatically re-enrolled January 1st of each calendar year if eligibility criteria are met
- Program Benefits automatically reset on January 1st of each calendar year
- A single online portal where practices can enroll and manage patients' benefits, submit claims, and monitor reimbursement status
- Simplified claims submission process – the program only requires a line-item Explanation of Benefits (EOB), claim forms are not required
- Patients with commercial insurance and Medicare Part A can participate in the program. Please see the appendix for specifics
- Administration assistance for some programs. Please see the appendix for specifics
- 180-day retroactive period from the first date of service to the date of enrollment into the co-pay program
- 365 days to submit a claim to the program from the date of service, (545 days for the Ocrevus brand ONLY)
- Contact center hours for the program are 9 AM ET – 8 PM ET

# PROGRAM ELIGIBILITY

In order to qualify for co-pay assistance, patients must meet the following criteria:

## Program Eligibility (Drug)

- Have been prescribed a Genentech medication for an FDA-approved indication
- Are 18 years of age or older, or have a caregiver or legally authorized person to manage the patient's co-pay assistance
- Have commercial (private or non-governmental) insurance. This includes plans available through state and federal health insurance exchanges*
- Reside and receive treatment in the U.S. or U.S. Territories
- Are **not** receiving assistance through the Genentech Patient Foundation or any other charitable organization for the same expenses covered by the program
- Are **not** a government beneficiary and/or participant in a federal or state-funded health insurance program (e.g., Medicare, Medicare Advantage, Medigap, Medicaid, VA, DoD, TRICARE)

## Program Eligibility (Administration)

- Have been prescribed a Genentech medication for an FDA-approved indication
- Are 18 years of age or older, or have a caregiver or legally authorized person to manage the patient's co-pay assistance
- Have commercial (private or non-governmental) insurance. This includes plans available through state and federal health insurance exchanges*
- Reside and receive treatment in the U.S. or U.S. Territories
- Are **not** a government beneficiary and/or participant in a federal or state-funded health insurance program (e.g., Medicare, Medicare Advantage, Medigap, Medicaid, VA, DoD, TRICARE)
- Are **not** receiving assistance through any other charitable organization for the same expenses covered by the program *(patients in the admin program can utilize the Genentech Patient Foundation*)
- Do **not** live or receive treatment in a restricted state (*Massachusetts or Rhode Island*)

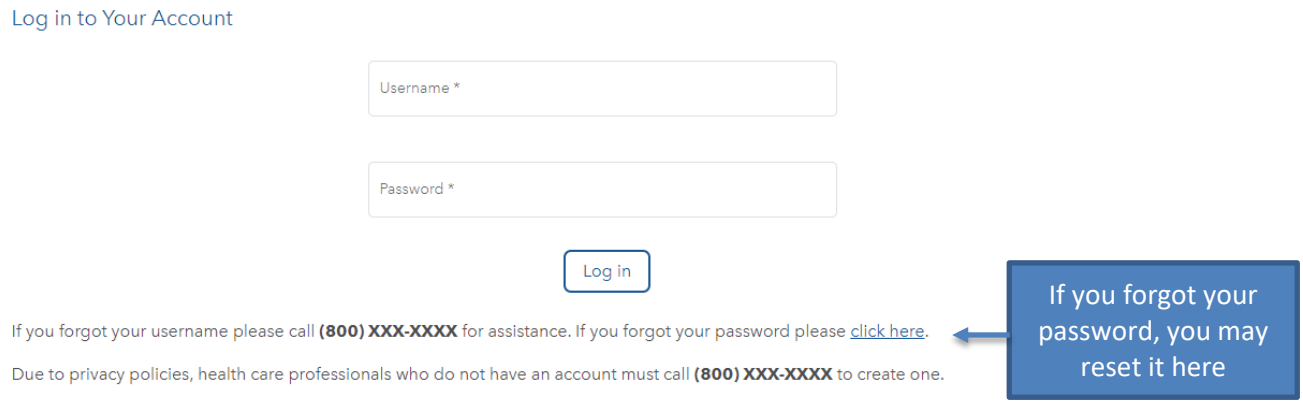
*Commercial insurance includes plans you received from your job or from the Health Insurance Marketplace. Government programs like Medicare and Medicaid are not commercial insurance.

# PORTAL REGISTRATION

To utilize the co-pay portal, users need to register with the program to create a provider portal account. By creating an account, you are able to perform actions such as:

- Viewing your entire patient list and enrollment status of all aligned patients
- Identifying patients that are not aligned to your HCP office (i.e., missing patients)
- Submitting claims online via a secure upload
- Viewing claims activity and status
- Managing portal users
- Receiving communications from the Genentech Co-pay Program

If you already have log in information for the portal, no action is required. Please note that after 5 incorrect log in attempts, you will be locked out of the system and will need to call the program for assistance.

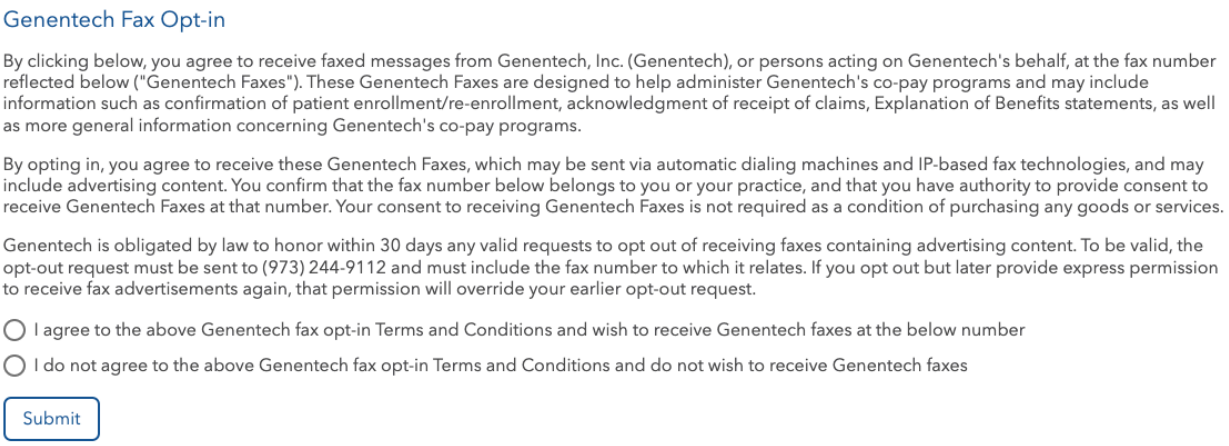



Accounts wishing to utilize the co-pay portal will need to contact the program by calling the appropriate co-pay program phone number (see appendix for contact information).

During the initial call, the following steps are required:

1. Provider works with the help desk agent to set up their Provider record and gather the following information:
    a. Provider NPIs for those practicing at the account
    b. Align with agent on how the account would like to view their information (e.g. – centralized view for all locations vs. per unique location)
    c. Account will inform help desk agent of preferred payment method (Check, Electronic Funds Transfer (EFT), or Debit/virtual Card)

2. Help desk agent will create new user(s) log ins and approve user account.
    a. New user(s) will receive a welcome email with a system-generated temporary password
3. User then authenticates and changes the password. The account is then identified as approved
4. Agree to Terms and Conditions for use of the portal and data privacy
5. Opt into receiving program faxes if you choose to do so – (highly recommended to stay informed on patient updates)



Genentech Fax Opt-in

By clicking below, you agree to receive faxed messages from Genentech, Inc. (Genentech), or persons acting on Genentech's behalf, at the fax number reflected below ("Genentech Faxes"). These Genentech Faxes are designed to help administer Genentech's co-pay programs and may include information such as confirmation of patient enrollment/re-enrollment, acknowledgment of receipt of claims, Explanation of Benefits statements, as well as more general information concerning Genentech's co-pay programs.

By opting in, you agree to receive these Genentech Faxes, which may be sent via automatic dialing machines and IP-based fax technologies, and may include advertising content. You confirm that the fax number below belongs to you or your practice, and that you have authority to provide consent to receive Genentech Faxes at that number. Your consent to receiving Genentech Faxes is not required as a condition of purchasing any goods or services.

Genentech is obligated by law to honor within 30 days any valid requests to opt out of receiving faxes containing advertising content. To be valid, the opt-out request must be sent to (973) 244-9112 and must include the fax number to which it relates. If you opt out but later provide express permission to receive fax advertisements again, that permission will override your earlier opt-out request.

◯ I agree to the above Genentech fax opt-in Terms and Conditions and wish to receive Genentech faxes at the below number

◯ I do not agree to the above Genentech fax opt-in Terms and Conditions and do not wish to receive Genentech faxes

Submit

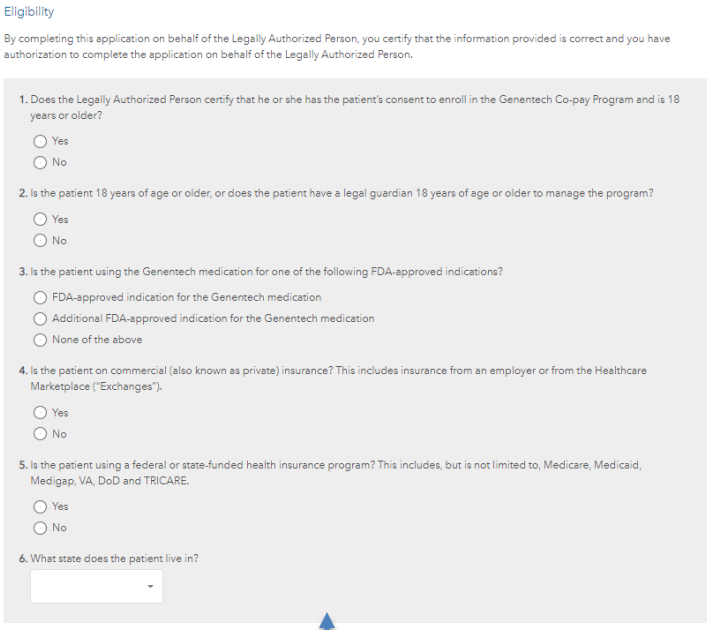
6. Users can receive an overview of the portal and how to navigate it if they choose to do so

# PROGRAM ENROLLMENT

During the enrollment process, the enroller may have the option to enroll into a drug only, administration only or drug and administration co-pay program, depending on the program's offering. The enroller will need to provide the following information:

## Eligibility Information

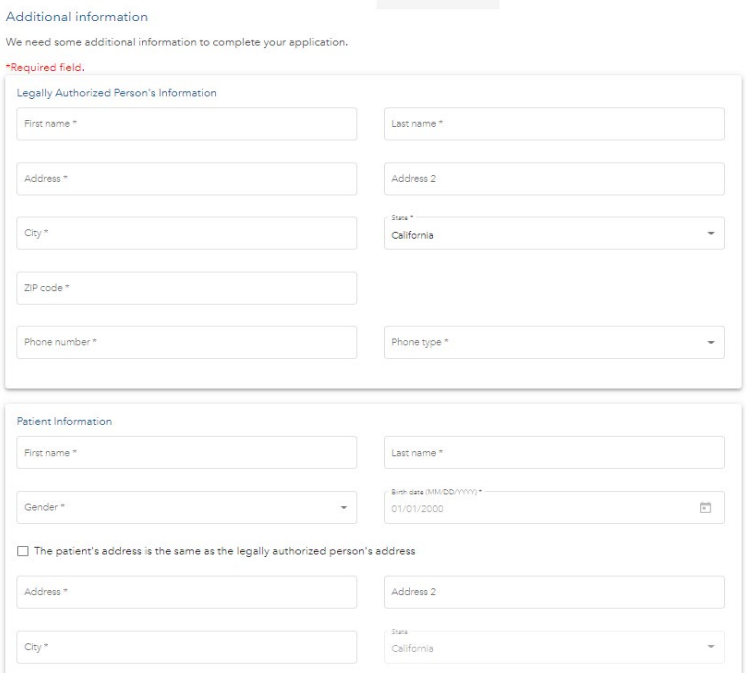
- Patient consent
- Patient age
- FDA-approved indication
- Confirm patient has commercial insurance
- Verify patient is not receiving any other forms of assistance
- Agree to program terms and conditions




Please note that this screen is a representative example of what you will see when enrolling a patient. The eligibility questions will be specific to the product co-pay program you are trying to enroll the patient into.

## Patient Demographics

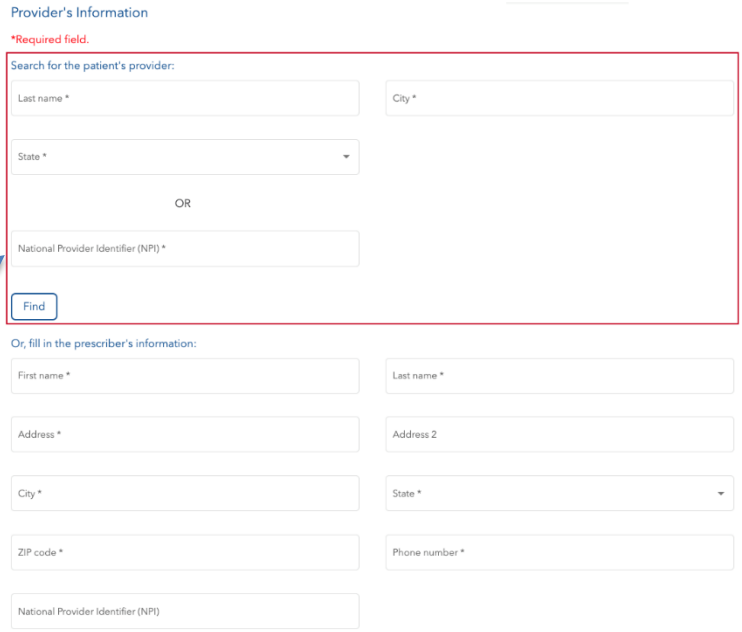
- Name, address, contact information
- Commercial insurance information



## Provider Information

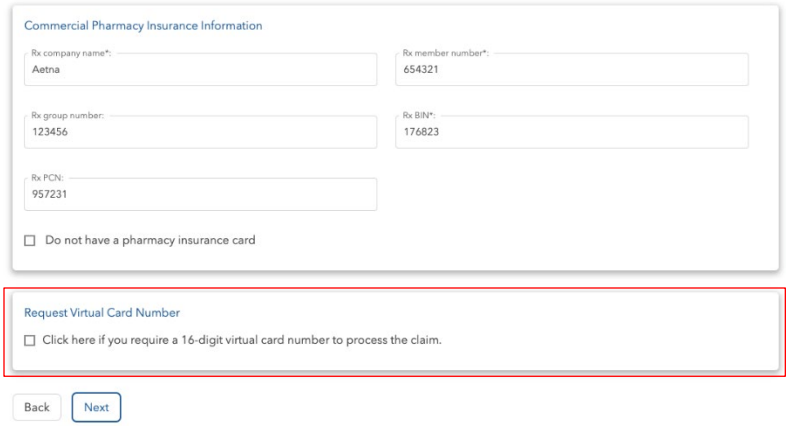
- Name, address, contact information
- NPI
- Treating facility information (if applicable)

You can use the search feature to locate the desired provider (highly recommended). If unable to locate the provider via the search feature, then users can manually enter the information.




## Virtual Debit Card Assignment Process

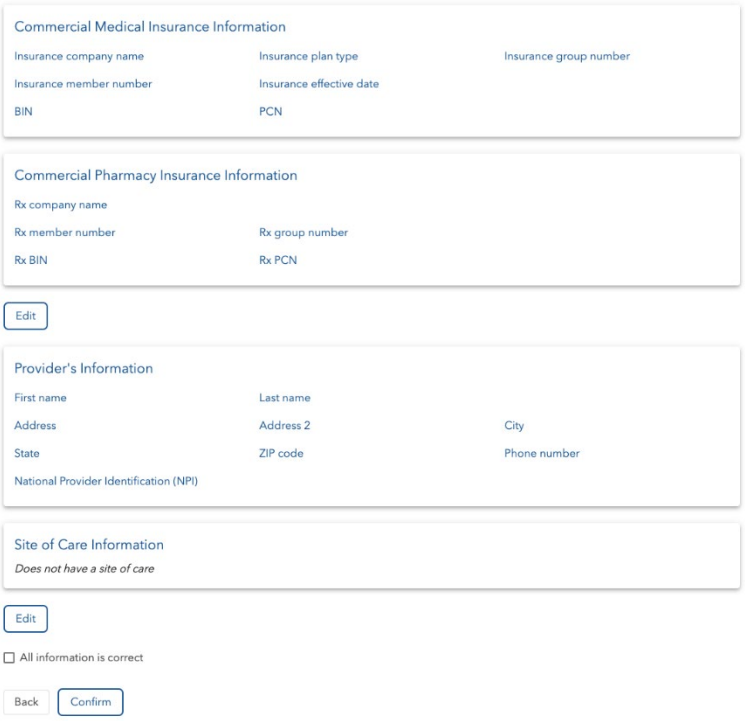
For those offices that receive payment via virtual debit card, during the patient enrollment process you MUST check the box here in order to assign a virtual debit number for your patient. Please note, if you do not check this box during the patient's enrollment, you will have to call the Program help desk to have a virtual debit number assigned.



The final step once all information has been populated is to confirm that all patient and physician information is accurate and click the “confirm” button.

Once a patient is successfully enrolled you will receive a confirmation message that will list the following:

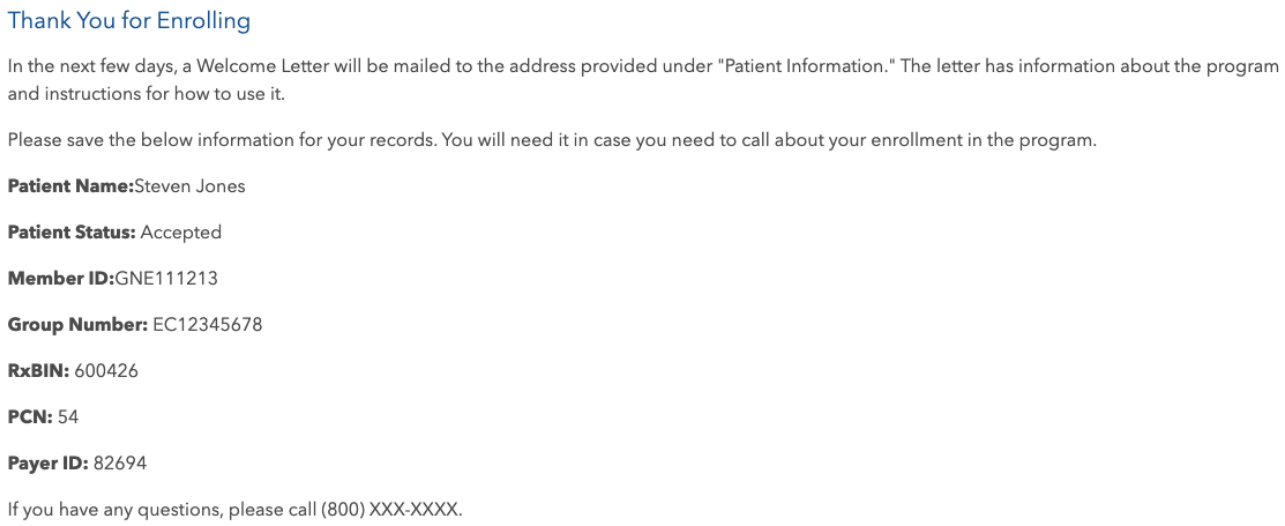
- Member ID
- Rx Bin
- Group
- PCN



## Enrollment Possible Outcomes

Genentech Co-pay Programs attempt to process enrollments in real time, providing near–immediate feedback. A response will be provided within two minutes. (Approved, Could Not Be Verified, Error, or Timeout).

If approved, the enroller will be provided the Member ID, Rx BIN, Group and PCN number.



Thank You for Enrolling

In the next few days, a Welcome Letter will be mailed to the address provided under "Patient Information." The letter has information about the program and instructions for how to use it.

Please save the below information for your records. You will need it in case you need to call about your enrollment in the program.

**Patient Name:**Steven Jones

**Patient Status:** Accepted

**Member ID:**GNE111213

**Group Number:** EC12345678

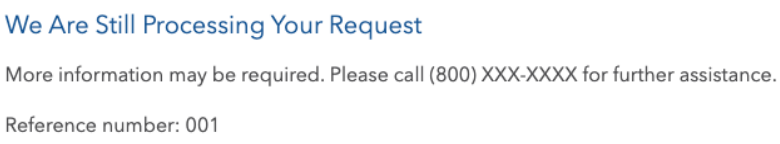
**RxBIN:** 600426

**PCN:** 54

**Payer ID:** 82694

If you have any questions, please call (800) XXX-XXXX.

If not approved due to demographic and/or insurance information incorrectly entered or if the real-time verification system times out, the enroller will be directed to call the Genentech Co-pay Program help desk for further assistance.



We Are Still Processing Your Request

More information may be required. Please call (800) XXX-XXXX for further assistance.

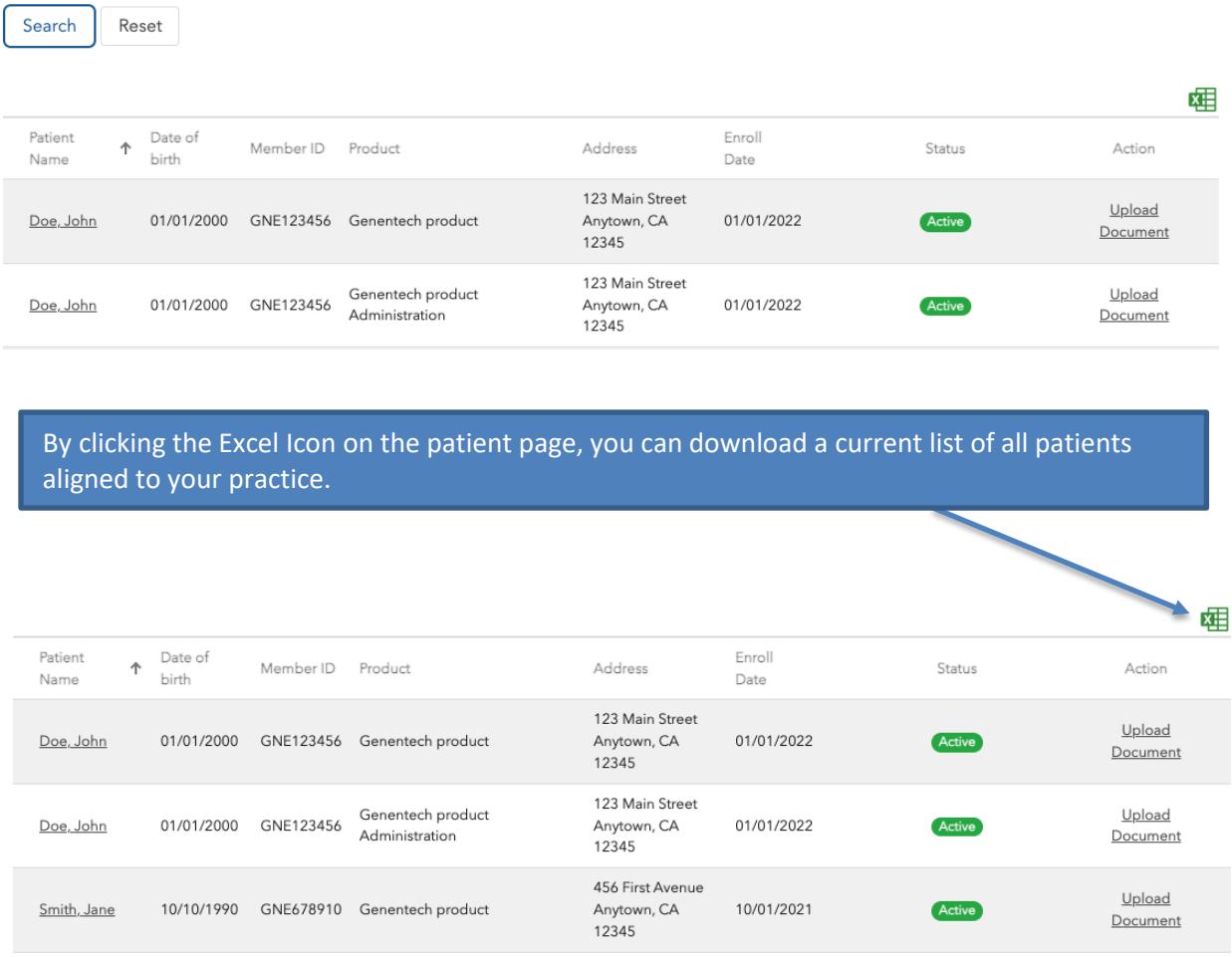
Reference number: 001

# PORTAL NAVIGATION & USE

## Commonly Used Tabs

### Home Tab


The home tab will take you to the patient search page of the portal. Here you can search for a specific patient or view the patient list for your office.



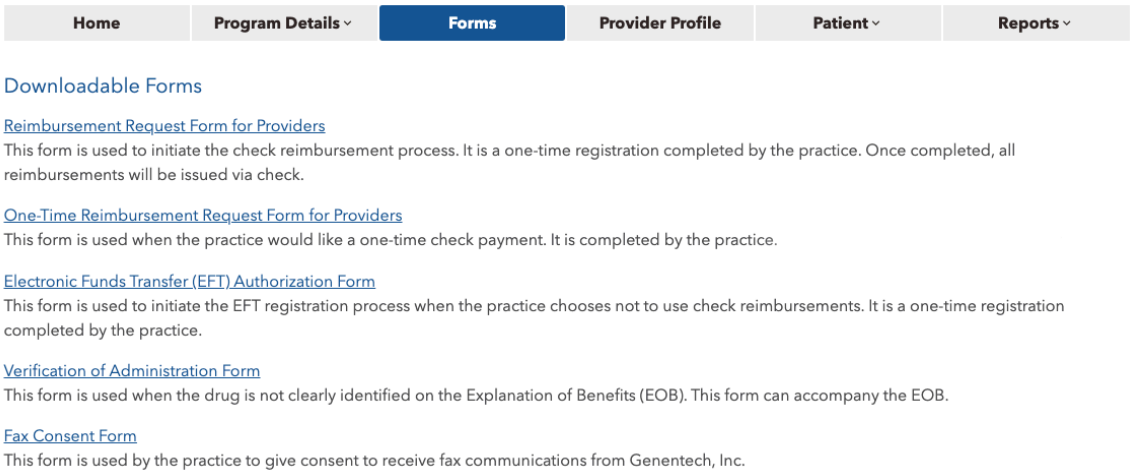

## Program Details

This tab contains four dropdowns:


- Offering and Eligibility – describes the program offering/benefits as well as the eligibility criteria for the program
- Program details – details how the program works for both major medical and pharmacy-based claims
- Terms and Conditions – lists the terms and conditions of the co-pay program
- User guide for the co-pay program

## Forms Tab

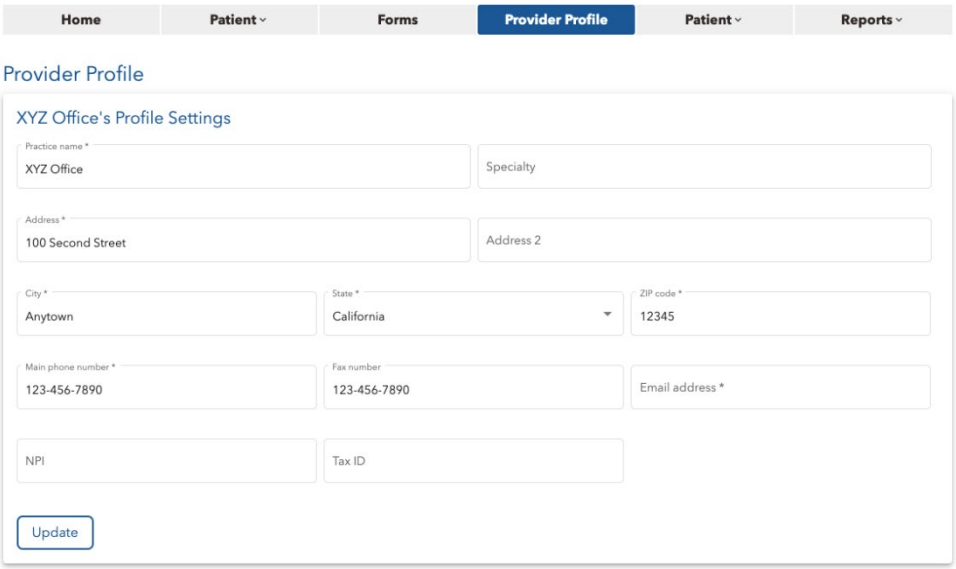
This tab contains downloadable forms for each program




- Check Reimbursement Request Form (HCP) – This is a one-time form that can be submitted to have all co-pay reimbursement sent to the address selected by the account
- One-time Check Reimbursement Form (HCP) – This is a form used to receive one-time check payments
- Electronic Funds Transfer (EFT) Authorization Form – This is a one-time form to submit in order to set up EFT payments to be deposited into the practice's account
- Verification of Administration (VOA) – This form is used for administration co-pay programs (Rituxan Immunology, Ophthalmology, Xolair & Ocrevus)
- Fax Consent Form – This form is used to receive fax communications

## Provider Profile Tab

On the provider profile you can view/update the demographic information for the provider.

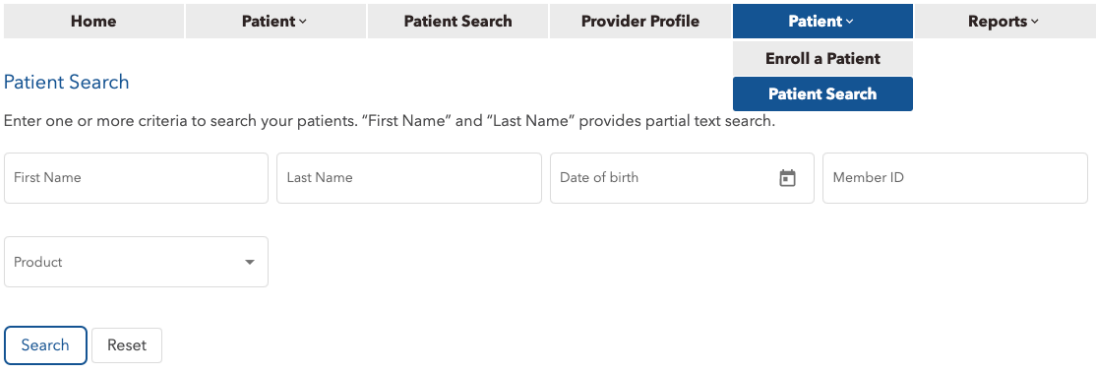



## Patient Tab


From here you can:

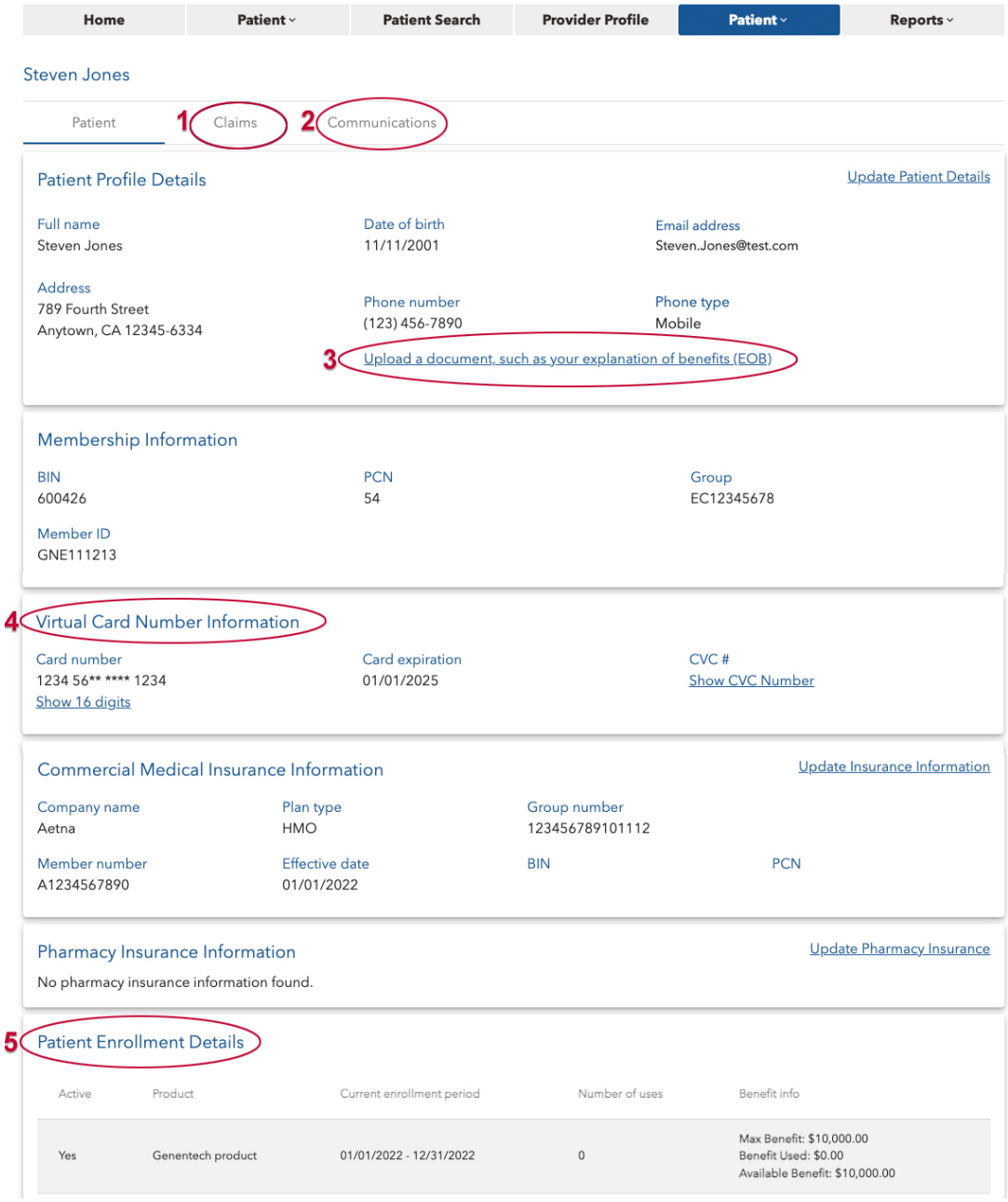
- Enroll a patient into the program, OR...


- Locate patients aligned to your practice in the patient list. You will need to set your search criteria (first name, last name, DOB, etc.). If you wish to view a list of all patients in your office, you may simply click the "Search" button without entering any criteria.



Once you locate the patient, you can view patient specific information such as:

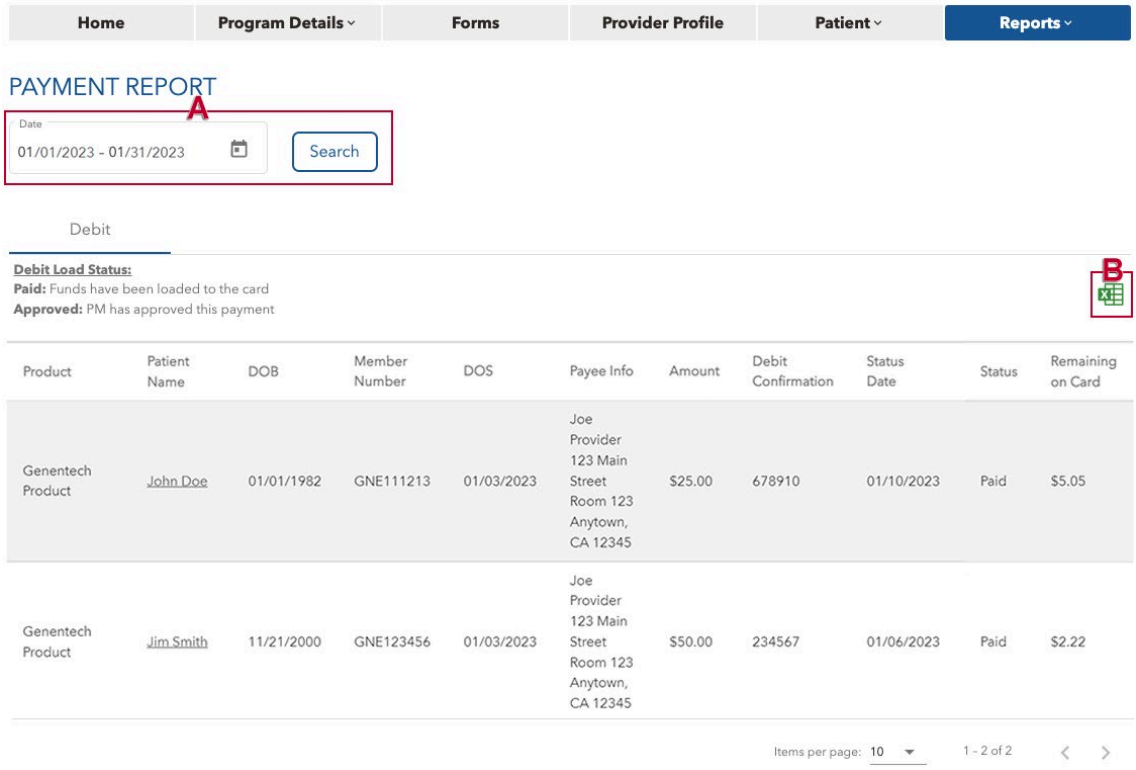
- View claims specific to the patient – **1**
- View communications sent to the patient – **2**
- Upload claims – **3**
- View debit/virtual card information – **4**
- See current patient enrollment period and benefits used/remaining – **5**



## Payment Tab

This tab allows users to view claims paid by the program for a 30-day timeframe (as selected by the user):

- Please note that the date range is for when the claim was processed by the program (it is NOT the date of service, or the claim submitted date) – **A**
- The information that is viewable on the screen can also be exported into an excel file for download by clicking on the Excel icon located on the payment screen – **B**




On the payment screen it will show the status of each payment and where it is in the payment process.

As each type of payment goes through the process, it will be shown on the payment screen so users can determine where it is in the payment process for each approved claim.

## CLAIMS SUBMISSION PROCESS

There are several ways to submit a claim to the co-pay program:

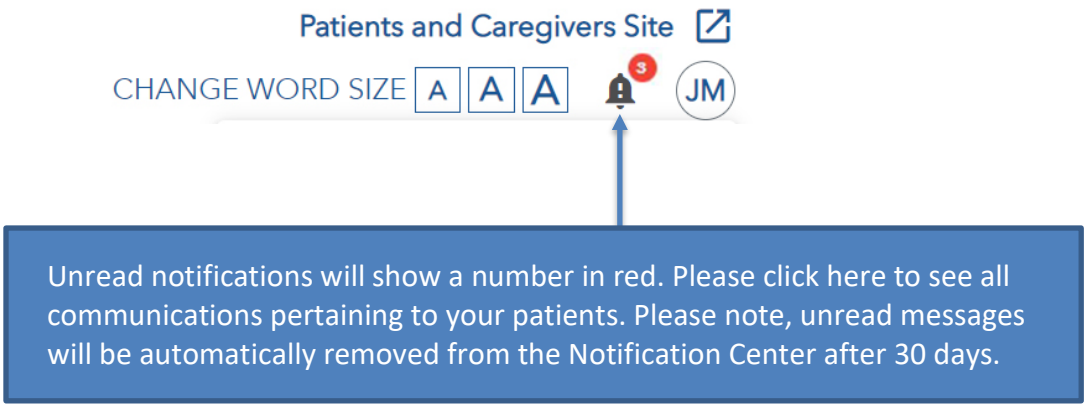
- Via Fax – see the appendix for program specific fax number
- Claim upload via the patient record – see page 12, item 3 of the guide to locate the link
- EDI – electronic data interchange – please see the appendix for details on how to set up your account to utilize EDI
- US Mail – Attn: Program name, [Street Address, City, State, Zip Code]

The program only requires a line-item EOB in order to adjudicate a claim. The EOB must contain the following information:

- Drug identifier (drug name, CPT or J-Code)
- Billed Amount
- Allowed Amount
- Paid Amount
- DOS
- Provider name
- Patient Responsibility
- Patient Name
- Payer name

The claim will be denied initially when the EOB does not contain all necessary information to adjudicate a claim. Additional documentation will be required in order to successfully adjudicate a co-pay claim.

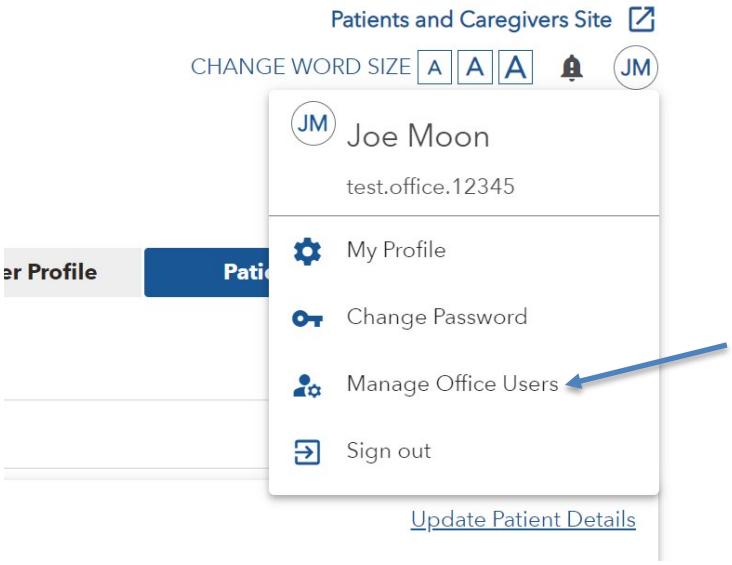
# NOTIFICATION CENTER

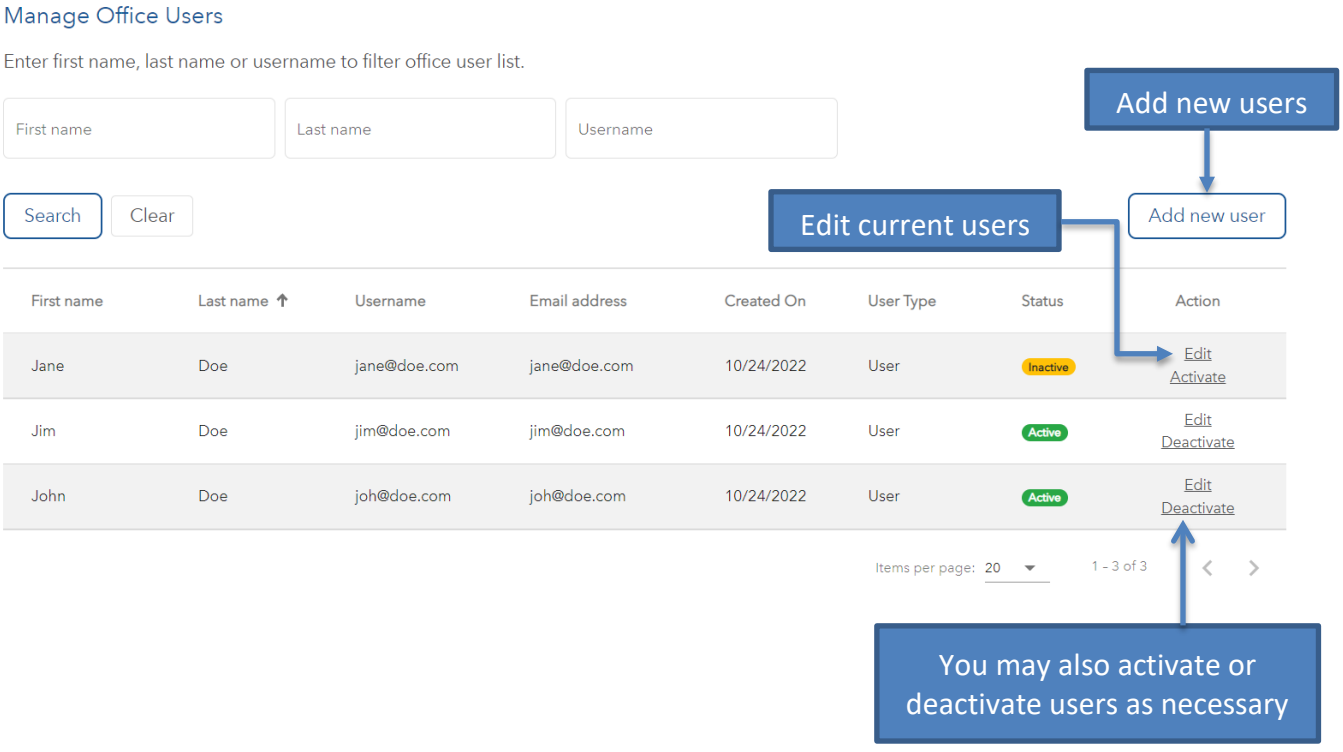


# USER MANAGEMENT

You have the ability to manage users in your practice including:

- Adding new users to grant portal access
- Editing existing user profiles
- Activating/deactivating user access to the portal



# FAQS/TROUBLESHOOTING

### Q: Can't see a patient? / Don't see a patient under a specific MD?

A: Contact the co-pay program via phone to ensure that all physicians and patients are properly aligned to your practice.

### Q: How can I view all locations (or only a single location) in the portal view?

A: Contact the program to work with a call center agent to set up your portal view in the manner that works best for your account (individual locations or all locations).

### Q: How long does the office have to submit the EOB?

A: 365 days from the date of service, 545 days from the date of service for Ocrevus® (ocrelizumab) ONLY.

### Q: How long is the retroactive assistance lookback period?

A: The retroactive lookback period is 180 days from the date of service to get a patient enrolled into the program.

### Q: If the drug is on NCCN guidelines but NOT FDA-approved, will the patient be eligible for the co-pay program?

A: No. In order to qualify for co-pay program benefits, the product must be for an FDA-approved use of the Genentech product.

### Q: What if I receive an error message during the enrollment process?

A: Contact a help desk agent to resolve the issue or obtain more information.

### Q: If a patient has both Medicare Part A and commercial insurance, will they be eligible for the co-pay program?

A: Patients with Medicare Part A and commercial insurance may qualify for the co-pay program if they meet all eligibility criteria.

### Q: What should I do if the patient has a change of insurance?

A: Please notify the program of insurance changes. Either the provider or the patient can call the program to provide it verbally, or they can go to the co-pay portal and locate the appropriate patient to update the insurance information.

### Q: What if I want to add a co-pay program to an already enrolled patient?

A: You can add drug or administration benefits to an existing patient enrollment by going to the program website and answering that the patient is already enrolled. The enroller will need to provide the necessary information to locate the patient record. Once located the system will let the enroller know which program they are currently enrolled in and ask if you would like to enroll the patient into the 'other' program (administration or drug) and you would complete the enrollment like any other enrollment. Enrollers can also call the program to speak with an agent.

### Q: How does auto re-enrollment work?

A: A patient is automatically re-enrolled into the program on January 1st each year as long as they continue to meet eligibility criteria.

### Q: What do I do if I forgot my username or if I've been locked out of my account?

A: Please call the toll free number for your specific program to speak with an agent for assistance.

### Q: What do I do if I forgot my password?

A: Please click on the password reset link on the log in page (see page 4).

### Q: How do I update my account profile? (demographic, contact info)

A: You could either update the information directly in the portal by going to the profile tab and editing the information directly. Or you can call the program specific number for your product to speak with a representative.

### Q: Does the co-pay program allow patients with governmental insurance to participate in the co-pay program?

A: All Genentech co-pay programs allow patients with commercial insurance and Medicare Part A to utilize the co-pay program as long as only the commercial insurance is covering a portion of the cost for the medication.

Esbriet allows for patients with commercial insurance and Medicare Parts A & B (but not parts C & D), to utilize the co-pay program as long as only the commercial insurance is covering a portion of the cost for the medication.

Actemra SC (only for RA, GCA and SSc indications only) allows for patients with commercial insurance and Medicare Parts A & B (but not parts C & D), to utilize the co-pay program as long as only the commercial insurance is covering a portion of the cost for the medication.

# APPENDIX

## Setting up EDI for your practice as a claim submission method

**Step One: Contact your billing software manager/vendor.**

- Ask if payer ID RISRX is available. Payer Name: RIS Rx
- If not, ask the software vendor to add RISRX – 351 Hospital Road, Suite 306, Newport Beach, CA 92663
- Confirm that it has been added as a payer with your software vendor as a secondary payer

**Step Two: Set up Electronic Remittance Advice**

- Request your practice software vendor to accept electronic remittance advice (EDI 835) transactions from RISRX (Note: ERAs are provided back to practice 5 to 7 business days after claim submission if the claim is paid)

**Step Three: Submitting claims***

- Add name of co-pay program (ie: [Brand] Co-pay Program) to the patient's insurance profile as a secondary payer
- Be sure to include payer ID RISRX, and the Member ID. The claim will be rejected if this information is not included
- Submit/transmit the claim. If reject codes come from your clearing house, these are handled like you would handle any rejection when submitting to a payer.
- ERA will be sent to practice software with claim approval approximately 5-7 business days after claim submission

**For offices submitting claims through EDI, be sure to contact your clearinghouse to ensure that they have the co-pay program payer ID loaded. Available payment types to EDI customers are EFT and paper check.*

## Payment Methods

There are three payment methods available to providers.

1. Debit/virtual card option: Once a claim is approved, if the account is opted in to receive faxes, they receive a fax back showing the claim has been approved. The card is loaded, and the funds are immediately available to the account. (Programs with virtual card must be keyed in by the HCP, programs with physical cards can be swiped)
2. Check process: Once a claim is approved, checks are issued within 24 hours and are delivered via U.S. mail. (Usually received 5-7 days after a claim is approved)
    a. Account must submit a check authorization request (form is available on the portal)
3. Electronic Funds Transfer (EFT) process: Once a claim is approved, the office will receive a fax back, if the account is opted in to receive faxes, showing the claim has been approved. It is a bank-to-bank transfer process to deposit funds into the practice's banking account. EFT trace numbers can be found on the Payment Report tab in the provider portal. This typically takes up to 10 business days for funds to be deposited
    a. Account must submit an EFT registration form which is available on the portal
4. Pharmacy Benefit Manager (PBM) – this is available for pharmacy adjudicated products. Submit claims with the co-pay Member ID and the program BIN, PCN and Group numbers (see page 22 and 23)

## Setting up your Account to utilize debit/virtual card as a payment method: (5 minutes)

Accounts wishing to utilize the debit/virtual card payment method need to contact the help desk to inform the program of their preferred payment method.

## Setting up your Account to utilize Checks as a payment method: (1-2 days upon receipt)

An account can complete the one-time Check Authorization Request Form to opt into receiving checks for all patient claims. The form can be found on the 'Forms' tab on the co-pay portal. Fill out the form and fax it into the co-pay program. All payments processed after the form has been submitted will then be paid out via check to the address provided on the Check Authorization Request Form.

## Setting up your Account to utilize Electronic Funds Transfer (EFT) as a payment method: (5-7 days upon receipt)

1. Download EFT form from the co-pay portal 'Forms' tab
2. Complete and fax the form to the program fax number (can be found in the appendix pages 22 and 23)
    a. *Note: all reimbursements freeze from this point until setup is complete*
3. Within two days, the Genentech Co-pay Program will call back to speak with the authorized person specified on the form. On this call:
    a. The authorized person will receive special log in credentials to manage the EFT process
    b. Authorized person logs in and enters bank information
4. A $.01 transaction will be run
5. Once the practice sees the transaction show up (~ 7-10 business days), the authorized person at the account notifies the Genentech Co-pay Program
6. All pending and future reimbursements will be paid via EFT to the registered bank account

## Program Specific Information*

| Product | Website | Phone/Fax # | Patient OOP | Drug Program Annual Maximum Benefit | Admin Program Annual Maximum Benefit | Timely Filing Period | Program Mailing Address | RxBIN PCN Group |
|---|---|---|---|---|---|---|---|---|
| Actemra®† (tocilizumab)/ Rituxan® (rituximab) Immunology | racopay.com | p: 855-722-6729 f: 800-334-3030 | As little as $5 | $15,000 | $2,000 (Rituxan only) | 365 days from date of service | P.O. Box 2106 Morristown, NJ 07962 | RxBin: 600426 PCN: 54 Group: RIT = EC38543004/ ACT = EC38541004 |
| Enspryng® (satralizumab) | enspryngcopay.com/ | p: 844-677-7964 f: 866-800-8432 | As little as $0 | $20,000 | Not applicable | 365 days from date of service | P.O. Box 2106 Morristown, NJ 07962 | RxBin: 600426 PCN: 54 Group: EC38526001 |
| Esbriet® (pirfenidone) | esbrietcopay.com | p: 877-780-4958 f: 888-280-8689 | As little as $5 | $25,000 | Not applicable | 365 days from date of service | P.O. Box 2106 Morristown, NJ 07962 | RxBin: 600426 PCN: 54 Group: EC38523002 |
| Evrysdi® (risdiplam) | evrysdicopay.com | p: 800-636-0316 f: 866-796-1448 | As little as $0 | $25,000 | Not applicable | 365 days from date of service | P.O. Box 2106 Morristown, NJ 07962 | RxBin: 600426 PCN: 54 Group: EC38525001 |
| Hemlibra® (emicizumab-KXWH) | hemlibracopay.com | p: 844-436-2672 f: 855-436-2672 | As little as $0 | $15,000 | Not Applicable | 365 days from date of service | P.O Box 15938 Newport Beach, CA 92659 | RxBin: 610020 PCN: PDMI Group: 99995209 |

*All Genentech co-pay programs allow patients with commercial insurance and Medicare Part A to utilize the co-pay program as long as only the commercial insurance is covering a portion of the cost for the medication.

†Actemra SC (only for RA, GCA and SSc indications only) allows for patients with commercial insurance and Medicare Parts A & B (but not parts C & D), to utilize the co-pay program as long as only the commercial insurance is covering a portion of the cost for the medication.

‡Esbriet allows for patients with commercial insurance and Medicare Parts A & B (but not parts C & D), to utilize the co-pay program as long as only the commercial insurance is covering a portion of the cost for the medication.

## Program Specific Information*

| Product | Website | Phone/Fax # | Patient OOP | Drug Program Annual Maximum Benefit | Admin Program Annual Maximum Benefit | Timely Filing Period | Program Mailing Address | RxBIN PCN Group |
|---|---|---|---|---|---|---|---|---|
| Ocrevus® (ocrelizumab) | ocrevuscopay.com | p: 844-672-6729 f: 855-672-6729 | As little as $0 | $20,000 | $1,500 first year $1,000 each subsequent year | 545 days from date of service | P.O. Box 2106 Morristown, NJ 07962 | RxBin: 600426 PCN: 54 Group: EC38517002 |
| Oncology | copayassistancenow.com | p: 855-692-6729 f: 877-885-2607 | As little as $0 | $25,000 per product | Not applicable | 365 days from date of service | P.O. Box 2106 Morristown, NJ 07962 | RxBin: 600426 PCN: 54 Group: EC38548001 |
| Ophthalmology | eyeoncopay.com/ | p: 855-218-5307 f: 855-320-0457 | As little as $0 | $15,000 (total regardless of switching product) | $1,000 | 365 days from date of service | P.O. Box 2106 Morristown, NJ 07962 | RxBin: 600426 PCN: 54 Group: EC38532001 |
| Pulmozyme® (dornase alfa) | pulmozymesupport.com | p: 877-794-8723 f: 833-307-2197 | As little as $30 | $10,000 | Not applicable | 365 days from date of service | P.O. Box 2106 Morristown, NJ 07962 | RxBin: 600426 PCN: 54 Group: EC38516003 |
| Xolair® (omalizumab) | xolaircopay.com | p: 855-965-2472 f: 866-440-0599 | As little as $0 | $15,000 | $1,500 | 365 days from date of service | P.O Box 15160 Newport Beach, CA 92659 | RxBin: 610020 PCN: PDMI Group: 99995223 |

*All Genentech co-pay programs allow patients with commercial insurance and Medicare Part A to utilize the co-pay program as long as only the commercial insurance is covering a portion of the cost for the medication.

# TERMS AND CONDITIONS FOR DRUG ASSISTANCE

The Co-pay Program ("Program") is valid ONLY for patients with commercial (private or non-governmental) insurance who have a valid prescription for a Food and Drug Administration (FDA)-approved indication of a Genentech medicine. Patients using Medicare, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD), TRICARE or any other federal or state government program (collectively, "Government Programs") to pay for their Genentech medicine are not eligible. The Program is not valid for Genentech medicines that are eligible to be reimbursed in their entirety by private insurance plans or other programs.

Under the Program, the patient may be required to pay a co-pay. The final amount owed by a patient may be as little as $0 for the Genentech medicine (see Program specific details available at the Program Website). The total patient out-of-pocket cost is dependent on the patient's health insurance plan. The Program assists with the cost of the Genentech medicine only. It does not assist with the cost of other medicines, procedures, or office visit fees. After reaching the maximum annual Program benefit amount, the patient will be responsible for all remaining out-of-pocket expenses. The Program benefit amount cannot exceed the patient's out-of- pocket expenses for the Genentech medicine. The maximum Program benefit will reset every January 1st. The Program is not health insurance or a benefit plan. The patient's non- governmental insurance is the primary payer. The Program does not obligate the use of any specific medicine or provider. Patients receiving assistance from charitable free medicine programs (such as the Genentech Patient Foundation) or any other charitable organizations for the same expenses covered by the Program are not eligible. The Program benefit cannot be combined with any other rebate, free trial, or other offer for the Genentech medicine. No party may seek reimbursement for all, or any part of the benefit received through the Program.

The Program may be accepted by participating pharmacies, physicians' offices, or hospitals. Once a patient is enrolled, the Program will honor claims with a date of service that precedes the Program enrollment date up to 180 days. Claims must be submitted within 365 days from the date of service unless otherwise indicated. Use of the Program must be consistent with all relevant health insurance requirements. Participating patients, pharmacies, physicians' offices, and hospitals are responsible for reporting the receipt of all Program benefits as required by any insurer or by law. Programs' benefits may not be sold, purchased, traded, or offered for sale.

The patient or their guardian must be 18 years of age or older to receive Program assistance. The Program is only valid in the United States and U.S. Territories, is void where prohibited by law and shall follow state restrictions in relation to AB-rated generic equivalents (e.g., MA, CA) where applicable. Eligible patients will be automatically re-enrolled in the Program on an annual basis. Eligible patients will be removed from the Program after 3 years of inactivity (e.g., no claims submitted in a 3-year timeframe). Program eligibility and automatic re enrollment are contingent upon the patient's ability to meet all requirements set forth by the Program. Healthcare providers may not advertise or otherwise use the Program as a means of promoting their services or Genentech medicines to patients.

The value of the Program is intended exclusively for the benefit of the patient. The funds made available through the Program may only be used to reduce the out-of-pocket costs for the patient enrolled in the Program. The Program is not intended for the benefit of third parties, including without limitation third party payers, pharmacy benefit managers, or their agents. If Genentech determines that a third party has implemented a program that adjusts patient cost-sharing obligations based on the availability of support under the Program and/or excludes the assistance provided under the Program from counting towards the patient's deductible or out-of-pocket cost limitations, Genentech may impose a per fill cap on the cost- sharing assistance available under the Program. Submission of true and accurate information is a requirement for eligibility and Genentech reserves the right to disqualify patients who do not comply from Genentech programs. Genentech reserves the right to rescind, revoke or amend the Program without notice at any time.

# TERMS AND CONDITIONS FOR ADMINISTRATION ASSISTANCE

The Administration Co-pay Program ("Program") is valid ONLY for patients with commercial (private or non-governmental) insurance who have a valid prescription for a Food and Drug Administration (FDA)-approved indication of a Genentech medicine. Patients using Medicare, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD), TRICARE or any other federal or state government program (collectively, "Government Programs") to pay for their Genentech medicine and/or administration services are not eligible. The Program is not valid for administration that is eligible to be reimbursed in their entirety by private insurance plans or other programs. If the patient chooses to enroll in the Drug Co-pay Program, the patient must separately enroll and meet all eligibility criteria of that program.

Under the Program, the patient may be required to pay a co-pay. The final amount owed by a patient may be as little as $0 for the administration of the Genentech medicine (see Program specific details available at the Program Website). The total patient out-of-pocket cost is dependent on the patient's health insurance plan. The Program assists with the costs of the administration of the Genentech medicine only. It does not assist with the cost of other administrations, medicines, procedures, or office visit fees. After reaching the maximum per treatment or annual Program benefit amounts, the patient will be responsible for all remaining out-of-pocket expenses. The Program benefit amount cannot exceed the patient's out-of-pocket expenses for the administration fees for the Genentech medicine. The maximum Program benefit will reset every January 1st. The Program is not health insurance or a benefit plan. The patient's non-governmental insurance is the primary payer. The Program does not obligate the use of any specific medicine or provider. The Program is valid for patients receiving free medicine from the Genentech Patient Foundation. The Program is not valid for patients receiving assistance from any other charitable organizations for the same expenses covered by the Program. The Program benefit cannot be combined with any other rebate, free trial, or other offer for the administration of the Genentech medicine. No party may seek reimbursement for all, or any part of the benefit received through the Program.

The Program may be accepted by participating pharmacies, physicians' offices, or hospitals. Once a patient is enrolled, the Program will honor administration claims with a date of service that precedes the Program enrollment up to 180 days. Claims must be submitted within 365 days from the date of service unless otherwise indicated. Use of the Program must be consistent with all relevant health insurance requirements. Participating patients, pharmacies, physicians' offices, and hospitals are responsible for reporting the receipt of all Program benefits as required by any insurer or by law. Programs' benefits may not be sold, purchased, traded, or offered for sale.

The patient or their guardian must be 18 years of age or older to receive Program assistance. The Program is only valid in the United States and U.S. Territories and is void where prohibited by law. The Program is not valid for Massachusetts or Rhode Island residents. Eligible patients will be automatically re-enrolled in the Program on an annual basis. Eligible patients will be removed from the Program after 3 years of inactivity (e.g., no claims submitted in a 3-year timeframe). Program eligibility and automatic re-enrollment are contingent upon the patient's ability to meet all requirements set forth by the Program. Healthcare providers may not advertise or otherwise use the Program as a means of promoting their services or Genentech medicines to patients.

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