PATIENT CONSENT FORM FOR VENCLEXTA® (venetoclax)

Genentech | ACCESS SOLUTIONS®
A Member of the Roche Group

Genentech-Access.com/VENCLEXTA
Phone: (888) 249-4918 **Fax:** (877) 313-2659
6 a.m.–5 p.m. (PT) M-F

ACS/020819/0019 02/19

Instructions for Patients

By completing this form you can:

- Learn about your health insurance coverage and other options to get your Genentech medicine
- Enroll into optional disease-specific education, patient support services and communication

Please follow these 3 steps to get started:

1. Read "About Your Consent."
2. Sign and date page 3. Please note you must sign the form to get support for your treatment.
3. Send in your completed form using one of the options below.

Genentech can start supporting you when **page 3** of this form is submitted by you or your doctor's office in one of the following ways:

Complete online at
Genentech-Access.com/PatientConsent

Take a photo and text it to
(650) 877-1111

Print, complete and fax it to
(877) 313-2659

A representative from Genentech Access Solutions or your doctor's office will call you to tell you about your coverage, costs and support for your treatment.

If you have any questions, talk to your health care provider or contact Genentech Access Solutions.

Helpful Terminology

Genentech: The maker of the medicine your doctor wants to prescribe. Genentech is committed to helping patients get the medicine their doctor prescribed.

Genentech Access Solutions: A team at Genentech that works with your doctor and health insurance plan to help you get your medicine.

Genentech Patient Foundation: A program that gives free Genentech medicine to people who don't have insurance coverage or who have financial concerns and meet certain eligibility criteria.

Household size: Number of people living in your household, including you.

Net household income: How much you and the members of your household make each year minus specific deductions. This is also frequently referred to as your Adjusted Gross Income or AGI. This information is needed to determine Genentech Patient Foundation eligibility.

Education and patient support services: Optional programs offered by Genentech to help you start and stay on your medicine. Services may vary based on your medical condition and could include co-pay assistance, clinical support, marketing communication and general disease information.

Deductible: The amount you pay for health care services or medicines out of pocket before your health insurance plan begins to pay.

Out-of-pocket costs: The amount not paid by the insurance plan that you must pay for your treatment. This includes deductibles, co-pays and co-insurance.

Co-pay assistance: Programs available to help eligible patients pay for their medicines.

Alternate contact: Someone you choose to be your contact person if Genentech Access Solutions cannot reach you.

If I receive free Genentech medicine from the Genentech Patient Foundation:

- I will not sell or give out this medicine since it is unlawful to do so. I am responsible to make sure these medicines are sent to a secure address when shipped to me, and I must control any Genentech medicine that I receive
- I understand that, for purposes of an audit, the Genentech Patient Foundation could ask me for a copy of my IRS 1040 form or other proof of income

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About Your Consent – This relates to 'Box 1' on page 3

Your personally identifiable information (PII) may include:

- Name and birthdate
- Address, telephone number and email address
- Important financial information, as necessary
- Information on your medical condition, as necessary
- Information about your health benefits or health insurance coverage

Who may see and use my PII

I authorize Genentech and/or Genentech Patient Foundation to (i) use my PII for the purpose of facilitating my access to Genentech products and providing the services described below, and (ii) further disclose my PII to others who are assisting them in these services, and to my health care provider(s), health care entities, pharmacies, and health plan(s) for purposes of providing these services.

Reasons for sharing and using my information may include:

- Working with my health care plan to understand coverage for Genentech products
- Applying to the Genentech Patient Foundation
- Determining my eligibility and enrollment into financial assistance services, including co-pay assistance
- Coordinating my prescription through a pharmacy, infusion site and/or health care provider's office
- Providing treatment reminders and education

I direct and authorize my physician, pharmacy and my health plan(s) to disclose my PII to Genentech and its partners, as necessary for Genentech to provide the above services.

Once I sign this Patient Consent Form and my PII is transmitted to Genentech and/or Genentech Patient Foundation, I understand that the Health Insurance Portability and Accountability Act (HIPAA) may no longer protect or prohibit the redisclosure of the PII disclosed to Genentech and/or Genentech Patient Foundation by my health care provider or others covered by the HIPAA laws. I understand that Genentech and Genentech Patient Foundation 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 can choose not to sign this form, but Genentech and Genentech Patient Foundation will not be able to assist me without it. However my health care providers and health insurer may not condition either my treatment or my payment, enrollment or eligibility for benefits on signing this form.

The length and terms of this form

- This form is valid for 3 years from the date I signed or the date I last enrolled, whichever comes first, unless a shorter period is required by law
- I agree that if I reside in the state of Maryland, this form will be valid for no longer than 1 year from the date I signed
- I have the right to cancel this authorization. If I cancel, this means that Genentech and/or the Genentech Patient Foundation will no longer use or share my PII, but this will not apply to PII already used or shared or when it is required by law. To cancel, I must send a written notice to Genentech. It can be sent by fax or by mail to the address below. If I cancel, I know that Genentech and the Genentech Patient Foundation will no longer be able to assist me with access to my Genentech products. The address is Genentech, 1 DNA Way, Mail Stop #858a, South San Francisco, CA 94080-4990

I understand that I, as the patient or signer, have a right to receive a copy of this signed form over the time it is valid.

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Required field (*)

Patient Information (to be completed by patient or their legally authorized person)

***First name:** _____ ***Last name:** _____

Home phone†: ( ) - Cell phone†: ( ) -

☐ OK to leave a detailed message? ☐ OK to send a text message?

Email: _____ Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Alternate Contact (optional) Full name: _____

Relationship: _____ Phone†: ( ) -

1 Patient authorization via signature is required in order to obtain services from Genentech Access Solutions and the Genentech Patient Foundation. By signing this box, you agree to the terms in the 'About Your Consent' section.

REQUIRED

Sign and date here

_____ / / _____
***Signature of Patient/Authorized Person** (A parent or guardian must sign for patients under 18 years of age) ***Date signed** (MM/DD/YYYY)

Person signing (if not patient)

_____ _____ _____
Print first name Print last name Relationship to patient

2 Financial Eligibility Information: Complete for Genentech Patient Foundation **only**

By completing this section, I am agreeing to the terms and conditions of the Genentech Patient Foundation outlined on page 1.

Household size (including you): _____ Annual net household income: ☐ Under $75,000
☐ $75,000 – $100,000 ☐ $100,001 – $125,000 ☐ $125,001 – $150,000 ☐ Over $150,000

Sign and date here

_____ / / _____
Signature of Patient/Authorized Person (A parent or guardian must sign for patients under 18 years of age) **Date signed** (MM/DD/YYYY)

3 Patient consent to enroll in **optional** disease-specific education, support programs, market research and communication that may be considered marketing. I understand my PII may be needed for me to participate in these programs.

Sign and date here to choose to enroll

_____ / / _____
Signature of Patient/Authorized Person (A parent or guardian must sign for patients under 18 years of age) **Date signed** (MM/DD/YYYY)

†By providing my phone number and signing Box 3, 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.

Once pages 3&4 have been completed, please text a photo of them to **(650) 877-1111**, or fax to **(877) 313-2659**. You can also complete this form online at **Genentech-Access.com/PatientConsent**.

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Required field (*)

VENCOMPASS™ Request support and resources from a dedicated Vencompass Nurse

This form is to request enrollment into VENCOMPASS; it is not a prescription or a specialty pharmacy provider form. Form must be completed by the health care professional and patient or legally authorized person. After completion of this form, patients will receive a call from a dedicated Vencompass Nurse within 1 business day to confirm enrollment.

Patient's information – To be completed by patient or legally authorized person.
Please print clearly. All fields marked with an asterisk (*) are required. Today's date: _____

*First name: _____ *Last name: _____

*Date of birth: _____ /_____ /_____ *Gender (check one) ☐ M ☐ F

Address: _____ City: _____ State: _____ *ZIP: _____

*Phone: _____ *Email address: _____

Best time to call: Monday–Friday ☐ Morning ☐ Afternoon ☐ Evening ☐ Check here if it is *not* okay to leave a message

*For which condition are you being treated? (This service is for approved VENCLEXTA indications only.)

☐ Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) ☐ Acute myeloid leukemia (AML)

If a legally authorized person is completing the form, please fill in the following lines:

First and last name: _____ Relationship to patient: _____

Phone: _____

By enrolling, you will receive your own Vencompass Nurse. Vencompass Nurses do not give medical advice and are trained to direct patients to their health care professionals for treatment-related advice, including further referrals. Your personal information will be used solely to provide you with the Vencompass Nurse support and communications and for AbbVie to perform research and analytics on a de-identified basis. For more information on AbbVie's privacy practices, visit www.abbvie.com/privacy.html. I understand that I do not have to sign this consent form and that it plays no role in getting my medicine, and it is not required to receive help from VENCLEXTA Access Solutions, a Genentech service.

☐ I would also like to receive news and updates about AbbVie's products, clinical trials, research opportunities and other information that may be of interest to me.

Prescriber information – To be completed by prescriber.
Please print clearly. All fields marked with an asterisk (*) are required. Stamp OK.

*Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

*Office contact name: _____ *Phone: _____ *Fax: _____