Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – Patient-Administered Drugs

Please do not send any additional documentation
Phone (888) 754-7651 - Fax (800) 305-1830

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed CellCept® (mycophenolate mofetil) therapy. Please complete all applicable sections below. Completion of this form does not guarantee coverage in GATCF.

My office received an initial claim denial or Prior Authorization (PA) denial.
Date of initial claim or PA denial: _____/_____/_____

Reason for initial claim or PA denial: (check one box)

☐ Administrative / billing / clerical Error
☐ Appeal deadline exceeded
☐ Diagnosis off-label
☐ Line of therapy
☐ Dosing
☐ Drug combination
☐ Exclusion – diagnosis or drug
☐ Experimental / investigational
☐ Labs / diagnostic testing/ biopsy
☐ No prior authorization (PA) obtained
☐ Not considered medically necessary
☐ Not seen by a specialist
☐ Patient demographics
☐ Physician and/or facility out of network
☐ Step therapy
☐ Untimely filing
☐ Other: _____

My office submitted a first-level appeal on: _____/_____/_____

My office received a first-level appeal denial on:_____/_____/_____

Reason for first-level appeal: (check one box)

☐ Administrative / billing / clerical error
☐ Appeal deadline exceeded
☐ Diagnosis off-label
☐ Line of therapy
☐ Dosing
☐ Drug combination
☐ Exclusion – diagnosis or drug
☐ Experimental / investigational
☐ Labs / diagnostic testing/ biopsy
☐ No prior authorization (PA) obtained
☐ Not considered medically necessary
☐ Not seen by a specialist
☐ Patient demographics
☐ Physician and/or facility out of network
☐ Step therapy
☐ Untimely filing
☐ Other: _____

My office received a peer-to-peer denial.
Date of review: _____/_____/_____
Denial reason:_____

My patient has met the daily/yearly cap for insurance coverage.
Date cap was met: _____/_____/_____
Date cap reset: _____/_____/_____

Please complete, sign and date the following statement (Required field (*))

Office Contact Signature*: _____Date*: ___/____/____
Patient Insurance Company Name: _____
Print Patient's First and Last Name: _____
Patient's Date of Birth: _____/_____/_____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements. I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.