



**PHYSICIAN'S STATEMENT OF MEDICAL NECESSITY (SMN)  
FOR RAPTIVA® [EFALIZUMAB] TREATMENT**



Phone 1-877-RAPTIVA (727-8482) Fax to 1-866-481-SPOC (7762)

*Patient Information*

Name (First and Last): \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/ZIP: \_\_\_\_\_  Male  Female  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Alternate Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

*Insurance Information*

Please attach an enlarged copy of both sides of insurance card(s). If not available, fill out completely. See instructions on reverse

Change of Insurance

**Primary**

HMO/EPO  PPO  POS  Indemnity  Separate Rx Card

Insurance: \_\_\_\_\_

Phone: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Employer: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_ PolGrp/# \_\_\_\_\_

**Secondary**

HMO/EPO  PPO  POS  Indemnity  Separate Rx Card

Insurance: \_\_\_\_\_

Phone: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Employer: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_ PolGrp/# \_\_\_\_\_

*Diagnosis*

Diagnosis:  Psoriasis (696.1)  Other, Specify by ICD9: \_\_\_\_\_ Date of diagnosis \_\_\_\_\_ or years with disease \_\_\_\_\_

*Medical Assessment Within The Last 12 Months*

See instructions on reverse

Severity:  Moderate  Moderate to Severe  Severe

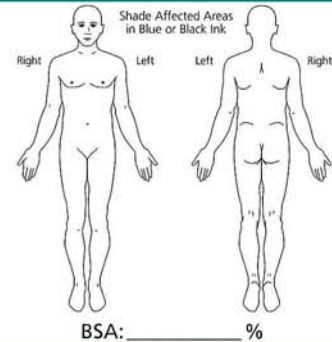
Type:  Plaque  Other \_\_\_\_\_

Significant Symptoms: \_\_\_\_\_

Prior Treatments:  Topicals  PUVA  UVB  Methotrexate  Cyclosporine

Oral Retinoids  Other \_\_\_\_\_

Medical Justification for Prescribing RAPTIVA: \_\_\_\_\_



*Prescription*

See instructions on reverse

Prescription Type:  New Start  Continuing Therapy  Restart  Drug Allergies: \_\_\_\_\_  NKDA

Injection Training  Office Staff Specialty Pharmacy:  In office  At home Patient Weight: \_\_\_\_\_ lbs ÷ 2.2 = \_\_\_\_\_ kg

RAPTIVA® [efalizumab] 125-mg single-use vial reconstituted with 1.3 mL Sterile Water for Injection (non-USP)

(Final Concentration 100 mg/mL efalizumab)

If new start or restart, give one-time conditioning dose of: 0.7 mg/kg x patient weight \_\_\_\_\_ (kg) = \_\_\_\_\_ mg ÷ 100 = \_\_\_\_\_ mL for injection

Then for continuing therapy, give weekly dose of: 1 mg/kg x patient weight \_\_\_\_\_ (kg) = \_\_\_\_\_ mg ÷ 100 = \_\_\_\_\_ mL for injection

Reconstitute each 125-mg single-use vial with 1.3 mL Sterile Water for Injection (non-USP) and inject SC \_\_\_\_\_ mg ( \_\_\_\_\_ mL) every week as directed by physician. Dispense  4 weeks  12 weeks Refill \_\_\_\_\_ times or through \_\_\_\_\_ (date)

Physician's Full Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ License#: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

I certify that RAPTIVA therapy for psoriasis is necessary for this patient. I will be supervising the patient's treatment accordingly.

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 in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) to Genentech's Single Point of Contact (SPOC™) program 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 the Genentech Access To Care Foundation program related to Genentech products, and (c) I appoint SPOC solely to convey on my behalf to the pharmacy chosen by the above-named patient the prescription described herein.

Prescriber's Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

\*This form cannot be processed without prescriber's signature and a signed PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION form.