AMGEN® Safety Net Foundation

Amgen Safety Net Foundation is a nonprofit patient assistance program that helps qualifying patients access Amgen medicines at no cost.

Are you eligible?

Apply for support if you meet the following requirements:

- **You have lived in the United States, American Samoa, Guam, Puerto Rico, or the U.S. Virgin Islands for six months or longer.**
- **You have a household income at or below:**
  $67,950..... for a household of 1 person
  $91,550..... for a household of 2 people
  Add $23,600 for each extra person
- **You are uninsured or your insurance plan excludes the Amgen medicine or its generic/biosimilar.**

What happens after I apply?

You and your physician will both be notified once a decision is made. If you are approved your physician will request replacement of the Amgen medicine after they administer the medicine to you. Replacement of the medicine is shipped directly to your physician.

Physicians must administer Amgen medicine(s) from their existing commercial stock to enrolled Foundation patients and request replacement for those medicine(s) from the Foundation using the **REPLACEMENT REQUEST** available at amgensafetynetfoundation.com.

Questions?

Contact us at **1-888-762-6436**, Monday through Friday 8am to 8pm Eastern Time.

PATIENT INSTRUCTIONS

Prior to applying

- If you are insured, contact your healthcare plan to understand your medicine coverage.
- If you have been denied coverage for the Amgen medicine (0% coverage) you must exhaust the maximum coverage appeals allowed by your health plan, and submit this support documentation. After a final denial has been received, ASNF may provide a retro 6-month replacement of product.
- If you are a low-income patient, apply to your local Medicaid office for healthcare insurance.

How to apply

STEP 1 Complete all sections of the **PATIENT APPLICATION** (pages 1-3). Applications missing required information cannot be processed.

STEP 2 Have your physician fill out the **PRESCRIBING PHYSICIAN & FACILITY INFORMATION** (page 4).

STEP 3 Have your prescribing physician fax the completed application to: **1-866-549-7239**.

PATIENT INFORMATION

Please PRINT all information on this form legibly

PATIENT APPLICATION

1. Which medicines have you been prescribed?

- ◯ **Aranesp®** (darbepoetina alfa)
- ◯ **AVSOLA™** (infliximab-axxq)
- ◯ **EPOGEN®** (epoetin alfa) for dialysis use only
- ◯ **EVENITY™** (romosozumab-aqqg)
- ◯ **KANJINTI™** (trastuzumab-anns)
- ◯ **Kyprolis®** (carfilzomib)
- ◯ **MVASI™** (bevacizumab-awwb)
- ◯ **Neulasta®** (pegfilgrastim)
- ◯ **NEUPOGEN®** (filgrastim)
- ◯ **Nplate®** (romiplostim)
- ◯ **Parsabiv™** (etelcalcetida)
- ◯ **Prolia®** (denosumab) injection
- ◯ **RIABNI™** (rituximab-arrx)
- ◯ **Vectibix®** (panitumumab) injection
- ◯ **XGEVA®** (denosumab)

2. Your info

Last name _____ **First name** _____ **Middle initial** _____

◯ **Male** ◯ **Female** **Date of birth** ___ (MM) / ___ (DD) / ___ (YYYY) **Social Security Number** ___ - ___ - ___

Address _____ **City** _____ **State** _____ **Zip** _____

Preferred telephone ___ - ___ - ___ ◯ **Home** ◯ **Mobile** ◯ **Work** **Best time to call** ◯ **Morning** ◯ **Afternoon**

Alternate telephone ___ - ___ - ___ ◯ **Home** ◯ **Mobile** ◯ **Work** **Preferred language** ◯ **English** ◯ **Spanish** ◯ **Other** _____

Email _____ By providing your phone number and email, you allow us to contact you to complete the application process.

3. Where you live

Select only what applies

Are you a: ◯ **U.S. citizen** ◯ **Resident alien living in the U.S. for 10 years or longer** ◯ **Neither**

You have lived in the U.S. or its territories (American Samoa, Guam, Puerto Rico, or U.S. Virgin Islands): ◯ **Greater than 6 months** ◯ **Less than 6 months**

You have lived in your current state: ◯ **Greater than 6 months** ◯ **Less than 6 months**

4. Your income

My household makes $ _____ annually. Your gross income includes all individuals in your household. This includes wages, Social Security, Social Security disability, unemployment, pensions, and any other income. You may be asked to provide proof of income.

How many people live in your household (including yourself)? ◯ **1** ◯ **2** ◯ **3** ◯ **4** ◯ **Other** _____

Your household size includes all individuals you reported on your U.S. Tax Return. If you did not file a tax return please include all individuals that live with you.

5. Your eligibility for government programs

Medicare

◯ **Yes** ◯ **No** Do you have Medicare A? **Effective Date** (MM/DD/YYYY) ___ / ___ / ___

◯ **Yes** ◯ **No** Do you have Medicare B? **Effective Date** (MM/DD/YYYY) ___ / ___ / ___

◯ **Yes** ◯ **No** Do you have Medicare D? **Effective Date** (MM/DD/YYYY) ___ / ___ / ___

Medicare ID #
It is on the front of your Medicare Card
___ ___ ___ ___-___ ___ ___-___ ___ ___ ___

Medicaid

◯ **Yes** ◯ **No** Do you have Medicaid?

◯ **Yes** ◯ **No** If yes, is it Emergency Medicaid?
Provide your Medicaid insurance information even if you only have Emergency Medicaid.

◯ **Yes** ◯ **No** Have you been denied Medicaid?
If yes, submit your recent Medicaid denial letter with this application (within the last 12 months).

◯ **Yes** ◯ **No** ◯ **N/A** Are you pregnant?

◯ **Yes** ◯ **No** Are you legally blind or have you received a Social Security Disability status?

◯ **Yes** ◯ **No** Do you receive Social Security Disability?

◯ **Yes** ◯ **No** Are you a parent or caretaker relative of a child under the age of 18?

Other

◯ **Yes** ◯ **No** Are you eligible for or enrolled in any federal, state, or local healthcare programs? Including VA, DoD, or IHS

6. Your insurance

Select the statement that applies to your insurance status:

◯ **I do not have health insurance.** You may skip Section 6.

◯ **I have health insurance (e.g. Commercial, Medicare, Medicaid) but the Amgen medicine or its generic/biosimilar is NOT covered.** You must complete Section 6.

Your primary insurance

Healthcare Coverage, Medicare, or Medicaid

Insurer name _____ **Plan name** _____ **Plan phone #** ___ - ___ - ___

Subscriber name _____ **Relationship to patient** _____ **DOB** ___ (MM) / ___ (DD) / ___ (YYYY)

Member ID/policy # _____ **Group #** _____

Your pharmacy insurance

Prescription Coverage or Medicare Part D

Insurer name _____ **Plan name** _____

Plan phone # ___ - ___ - ___ **PCN #** _____ **BIN #** _____

Subscriber name _____ **Relationship to patient** _____

Member ID/policy # _____ **Group #** _____

Your physician's information

Last name _____ **First name** _____ **Phone #** ___ - ___ - ___

Address _____ **State** _____ **Zip** _____

PATIENT CERTIFICATION AND AUTHORIZATION

Amgen Safety Net Foundation "the Foundation" is a nonprofit patient assistance program that helps qualifying patients access Amgen medicines at no cost.

Patient Certification

I certify that:

- The information I provided on the Foundation application form is complete and accurate.
- I will not request reimbursement from any insurance carrier or government health benefit program for Amgen medications that I receive from the Foundation.
- I will notify the Foundation within thirty (30) days if my financial status or health insurance coverage changes.
- If I decide to enroll in a Medicare Part D plan, I will inform the Foundation at the number below prior to enrolling. If I receive notice that I have "auto-enrolled" in a Medicare Part D plan, I will immediately inform the Foundation.
- I will not sell, trade, or distribute Amgen medications given to me by the Foundation.

I understand that completing the Foundation application form is not a guarantee of eligibility for the Foundation. I also understand that the Foundation may change or discontinue the program at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year. I understand that if I am currently enrolled in a Medicare part D plan, I cannot utilize my Part D plan benefits for medications received through Amgen Safety Net Foundation for the duration of my enrollment in the Foundation.

Any medication I receive through Amgen Safety Net Foundation will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D. The Foundation reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen medications under this program to any patient or facility.

Fair Credit Reporting Act (FCRA) Authorization

I am providing written instructions authorizing the Foundation and its vendor to obtain my consumer report from a consumer reporting agency to be used solely for the eligibility determination process for programs administered by the Foundation.

Amgen Safety Net Foundation is not a state or federally funded program. The Foundation is sponsored solely by Amgen Inc.

Amgen Safety Net Foundation does not charge patients a fee for its assistance. Amgen Safety Net Foundation is not affiliated with third parties who charge a fee for assistance with enrollment or medication refills. If you are being charged a monthly fee for support from the Amgen Safety Net Foundation, the organization billing you is not the Amgen Safety Net Foundation and you are being charged for support that the Amgen Safety Net Foundation can provide to you directly at no cost.

THIS FORM REQUIRES A PATIENT'S PRINTED NAME, SIGNATURE AND DATE OF SIGNATURE IN ORDER FOR THE FOUNDATION TO BEGIN PROCESSING THE APPLICATION

Printed name of patient

Name of legal guardian (if needed)

Signature of patient (or legal guardian)

Dated MM/DD/YYYY

Please proceed to the next page.

Patient Authorization

I authorize the Foundation and its contractors and business partners to use and/or disclose my personal information, including my personal health information, for the following purposes:

- To determine my eligibility for and assist with my continued participation in the Foundation.
- To contact me to seek feedback on the Foundation's services.

I understand that my personal health information may include any information, in electronic or physical form, in the possession of or derived from a health care provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor ("Health Care Provider"). This may include information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I also authorize and instruct my Health Care Provider(s) to disclose my personal health information to the Foundation for the purposes stated above.

I understand that I may refuse to sign this form, but if I refuse to sign it or revoke my authorization, I will not be able to receive assistance from the Foundation. I understand that signing this form is not a condition for receiving any medical care outside of the Foundation assistance and that my Health Care Provider will not condition my medical treatment or insurance benefits on my agreement to sign this form.

I understand that once I provide my personal information to the Foundation, or my Health Care Provider has provided my personal information to the Foundation pursuant to this authorization, federal privacy laws (including HIPAA) may not prevent redisclosure of this information; however, the Foundation has agreed to protect my personal information by using and disclosing it only for the purposes described above or as required by law.

I understand that I may receive a copy of this form at any time by contacting the Foundation at 1-888-762-6436 and I may revoke it by mailing a revocation to PO Box 18769, Louisville, KY 40261-7821. A revocation must be in writing and is not effective to the extent that action has already been taken based on this authorization.

I understand that this authorization will expire one (1) year after the date it is signed below or one (1) year after the last date I receive medication from the Foundation, whichever is later.

By providing my phone number I authorize the Foundation to contact me by phone through the use of automated dialing machines and artificial or prerecorded messages for the purposes described above. I understand that these communications may discuss Amgen medications and I authorize the Foundation to leave voicemail messages.

THIS FORM REQUIRES A PATIENT'S PRINTED NAME, SIGNATURE AND DATE OF SIGNATURE IN ORDER FOR THE FOUNDATION TO BEGIN PROCESSING THE APPLICATION

Printed name of patient _____ **Name of legal guardian (if needed)** _____

Signature of patient (or legal guardian) _____ **Dated** MM/DD/YYYY _____

By signing above, I am indicating that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal guardian for the Foundation and its contractors and business partners to use and share the personal information I provide for the purposes described within the Authorization above.

AMGEN® Safety Net Foundation

Give this page to your prescribing physician to complete and fax along with your completed application.

PRESCRIBING PHYSICIAN & FACILITY INFORMATION

Patient

Patient name _____ (Last) _____ (First) **Date of birth** ____ / ____ / ____ (MM / DD / YYYY)

Medicines

- ◯ **Aranesp®** (darbepoetin alfa)
- ◯ **AVSOLA™** (infliximab-axxq)
- ◯ **EPOGEN®** (epoetin alfa) for dialysis use only
  Is the patient on dialysis? ◯ Yes ◯ No
- ◯ **EVENITY™** (romosozumab-aqqg)
- ◯ **KANJINTI™** (trastuzumab-anns)
- ◯ **Kyprolis®** (carfilzomib)
- ◯ **MVASI™** (bevacizumab-awwb)
- ◯ **Neulasta®** (pegfilgrastim)
- ◯ **NEUPOGEN®** (filgrastim)
- ◯ **Nplate®** (romiplostim)
- ◯ **Parsabiv™** (etelcalcetide)
- ◯ **Prolia®** (denosumab) injection
  ◯ For Bone Health ◯ For Oncology
- ◯ **RIABNI™** (rituximab-arrx)
- ◯ **Vectibix®** (panitumumab) injection
- ◯ **XGEVA®** (denosumab)

Facility

◯ **Free-standing dialysis center** ◯ **Hospital dialysis center** ◯ **Infusion facility** ◯ **Specialty hospital** ◯ **Community hospital** ◯ **Hospital pharmacy** ◯ **Physician's office** ◯ **Pharmacy** ◯ **Other** _____

Pharmacy Director

Pharmacy director name _____ (Last) _____ (First)

Phone ____ - ____ - ____

Facility Contact

Facility name _____

Facility contact name _____ **Title** _____

Phone ____ - ____ - ____ **Fax** ____ - ____ - ____ All communications will be sent to this fax number.

Street Address _____ (Street (PO BOX not accepted)) _____ (City) _____ (State) _____ (Zip)

Facility National Provider ID (NPI) _____ **Facility Transaction Access Number (PTAN)** _____

Prescribing Physician

Prescribing physician name _____ (Last) _____ (First)

Phone ____ - ____ - ____

Street address _____ (Street (PO BOX not accepted)) _____ (City) _____ (State) _____ (Zip)

Physician National Provider ID (NPI) _____ **Physician Transaction Access Number (PTAN)** _____
Required if the patient has Medicare

Diagnosis code _____ **ICD-10 code** _____ **Tax ID** _____

◯ **Yes** ◯ **No** Is this application and associated forms being completed by a third-party (TPA), an agent, or a service provider authorized to act on behalf of the facility? ⚠ **Failure to disclose the use of a Third Party Administrator could result in withdrawal from participation in the Foundation.**

FACILITY CERTIFICATION

By submitting this application, I agree to the following:

- I will provide Amgen medicines for patients in a medically appropriate manner based on a valid physician's order or prescription.
- I understand that Amgen Safety Net Foundation, "the Foundation" reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen medicines under this program to any patient or facility.
- I understand that medicine is provided on a replacement basis. Participating physicians are required to stock the medicine and apply for replacement medicine through the Foundation.
- I understand that an insurance verification may be required to determine a patient's eligibility for the Foundation.
- I understand that the medicine received through the Foundation is for medically needy patients living in the United States and its territories.
- I certify that I will not charge or cause any other party to charge any third party or patient for Amgen medicines for which replacement is sought under the Foundation. I further certify that all medicine received in connection with the Foundation will replace such medicine; be administered at no cost for treatment of needy patients who meet the Foundation criteria; and, that no part of any charges for Amgen medicines replaced under the Foundation will be claimed as bad debt.
- I understand that the Foundation is available for outpatient use only. I certify that no replacement will be requested for medicine administered in the hospital inpatient setting.
- I represent that the information contained in all patient applications under my facility, including the patient application form will be complete and accurate to the best of my knowledge. This representation does not require my independent investigation of the information. If I become aware of any changes in the patient's circumstances that affect the Foundation eligibility, I agree to notify the Foundation immediately.
- I agree to release or make available to an authorized Foundation representative the medical and financial records for the Foundation patients who have provided consent for such disclosure for the sole purpose of verifying patients' eligibility for the Foundation. I agree that I will not provide patient information without obtaining appropriate consent from each patient prior to releasing or making available to the Foundation such records or information.
- I further certify that I am authorized to act for the institution for which I am signing.

Signature of facility contact _____ **Printed name of facility contact** _____ **Date signed** MM/DD/YYYY