

Form B: Patient Enrollment Form Instructions

Thank you for your interest in enrolling your patient in The Safety Net Foundation. The Foundation is a non-profit program that helps needy patients obtain access to Amgen products.

To apply for the Foundation:

1. Make sure the facility is enrolled as a Foundation Sponsor via Form A: Sponsor Enrollment Form – only needs to be completed once upon Sponsor’s initial enrollment into the Foundation. (Not required for Nplate or Sensipar)
2. Fill out the patient and physician information on the enclosed Form B: Patient Enrollment Form.
3. Fill out the sponsor information on the enclosed Form B: Patient Enrollment Form (Not required for Nplate or Sensipar)
4. Make sure patient signature is on Form B: Patient Enrollment Form
5. Provide family size on Form B: Patient Enrollment Form (include number of people in household) in the financial section.
6. Provide proof of patient’s household income along with Form B: Patient Enrollment Form. You or your patient may submit any **one** of the following:
 - o latest federal or state tax return,
 - o latest W-2 statement,
 - o SSDI/SSI award letter,
 - o bank statements (last 3 months showing income deposits),
 - o pay stubs (last 2 pay stubs), **or**
 - o state program acceptance letter or card (e.g. ORSA).

If the patient does not have proof of income, you may complete **one** of the following forms:

- o notarized income statement (form enclosed), **or**
 - o attestation statement with two signatures (form enclosed).
7. Fax or mail the completed Form B: Patient Enrollment Form and proper income documentation to:

The Safety Net Foundation
PO Box 13185
La Jolla, CA 92039-3185
Tel: 1-888-SN-AMGEN (1-888-762-6436)
Fax: 1-866-549-7239

For any questions please call 1-888-762-6436, Monday through Friday, 9am to 8pm Eastern Time.

Sincerely,

The Safety Net Foundation

FORM B: PATIENT ENROLLMENT FORM

Instructions: This form should be used to assess The Safety Net Foundation eligibility for Amgen products. For assistance in completing this application, please call 1-888-SN-AMGEN (1-888-762-6436). Submission of this form is required to begin enrollment of a patient in The Safety Net Foundation sponsored by Amgen. Information supplied on this form will be strictly confidential.

Patient Information

Patient's Name: _____
Social Security Number: _____ Date of Birth: _____ Gender: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Is the patient a US Resident? Yes No
Patient Email: _____

Facility Customer Number: _____

Sponsor (Facility) Mailing Information

(Sponsor information is not needed for Nplate™ or Sensipar® patients. Go to Physician Information section for these products.)

Sponsor (Facility) Name: _____
Contact Person Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

Sponsor (Facility) Product Shipping Information

Check if shipping is same as mailing information

Confirm address where product should be shipped (if different from above.)

Sponsor (Facility) Name: _____
Shipment Contact Person Name: _____
Address: _____
(PO Box is not accepted)
City: _____ State: _____ Zip: _____
Telephone: _____

Patient Name _____

Physician Information

Physician Name: _____

Physician Facility Name: _____

Check if address is same as facility mailing information Check if address is same as facility shipping information

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Insurance Information (Please complete one of the boxes below to describe your health insurance)

() I do have insurance (Whether it covers the product or not) (Please fill out the insurance coverage section)

() I do not have insurance and I am not eligible for any public health insurance

<p>Insurance Coverage (Ex: Blue Shield of CA, AARP, VA/DOD, Indian Health Service, Discount Card Program)</p> <p>Primary Insurance Name: _____</p> <p>Policy Holder Name: _____</p> <p>Supplemental Insurance Name: _____</p> <p>Policy Holder Name: _____</p> <p>Secondary Insurance Name: _____</p> <p>Policy Holder Name: _____</p>	<p>Medicare (A, B) <input type="checkbox"/> Yes <input type="checkbox"/> Denied <input type="checkbox"/> Pending <input type="checkbox"/> N/A Effective Date: _____ Telephone: () _____</p> <p>Medicare Part D (Prescription Drug Plan) <input type="checkbox"/> Yes <input type="checkbox"/> Denied <input type="checkbox"/> Pending <input type="checkbox"/> N/A Effective Date: _____ Plan Name: _____ Telephone: () _____</p> <p>Medicaid Effective Date: _____ <input type="checkbox"/> Yes <input type="checkbox"/> Denied <input type="checkbox"/> Pending <input type="checkbox"/> Emergency <input type="checkbox"/> N/A Telephone: () _____</p>
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Financial Information

Household Income: \$ _____ Source of Income: _____

Number of people in your household: _____

Product Information

Products Utilized by Patient:

_____ Aranesp® (darbepoetin alfa) EPOGEN® (Epoetin alfa) _____ Neulasta® (pegfilgrastim)
 _____ NEUPOGEN® (Filgrastim) _____ Nplate™ (romiplostim) _____ Sensipar® (cinacalcet HCl)
 _____ Vectibix® (panitumumab)

What therapeutic area is this patient being treated for?

_____ Oncology _____ Nephrology _____ Hematology

For EPOGEN® patients:

Is the Patient Currently on Dialysis? Yes No

First Date of Dialysis _____

For Nplate™ patients:

Nplate™ NEXUS Patient ID#: _____

Nplate™ NEXUS Physician ID#: _____

FORM B: PATIENT ENROLLMENT FORM

Patient Name _____

My doctor has prescribed Amgen products for me and I would like to receive the drug free of charge through The Safety Net Foundation (the "Foundation"). In order to participate, I hereby certify that the financial/insurance information listed above is accurate. I agree that this information can be provided to the Foundation, Amgen, and any agent of Amgen or the Foundation authorized to perform services on behalf of the Foundation.

I understand that, in order to determine my eligibility to participate in the Foundation, the Foundation needs information about my family income, and my health insurance. I agree to permit information about me to be provided to the Foundation, Amgen, and any agent of Amgen or the Foundation authorized to perform services on behalf of the Foundation, which will include a verification of my coverage with my insurance company, and to update my records to show that I continue to qualify for the Foundation. I further authorize the Foundation to provide Amgen with information concerning any assistance provided to me by the Foundation.

I also understand that my information may be provided to clinicians, social workers, and family members if reasonably necessary to complete the application or coordinate assistance. I understand that my assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that the Foundation reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

- I would like to receive Amgen products free of charge from The Safety Net Foundation. I do not have, nor am I eligible for, any private or public health insurance other than that listed above. I do not have, nor am I eligible for, any other form of public assistance with my medical expenses.
- I certify that I will not request reimbursement from any insurance carrier or government health benefit program for any Amgen products I receive from the Foundation.
- I certify that the above information is correct to the best of my knowledge. I understand that this information will not be used for any other purpose unless I give written consent, the government requires it, or The Safety Net Foundation removes my name and any other identifying information.
- I understand that The Safety Net Foundation may change or stop this program with respect to any patient, or in its entirety, at any time. I also understand that, although Amgen products may be given to me free of charge now, this does not mean I will be entitled to receive it free of charge indefinitely.
- I will not sell, trade, or distribute Amgen products given to me by The Safety Net Foundation.
- I understand that The Safety Net Foundation and such distributor as the Foundation may designate, may need to obtain my medical records from my physician and related information, including but not limited to my name, Social Security number, address, and date of birth, in order to assure continuity of care and in order for me to receive Amgen products. I authorize my physician to release to the Foundation all medical records and related information that may be necessary or helpful to the provision of Amgen products. I also authorize the Foundation, and its agents, to release medical information and related information to each other for purposes of my health care and in order for me to receive Amgen products. A photocopy of this authorization will be as valid as the original.
- I understand that The Safety Net Foundation, or its agents may need to work with my social worker or other dialysis center agent to case manage and coordinate care, including drug refills, on my behalf.

This consent expires the latter part of 1 year after the date of execution or 1 year after the last date I receive product under the program. I understand that this information identifying me will not be used for any purpose other than for the Foundation unless: (i) I give written consent, (ii) such disclosure is required by the government, or (iii) my name and any other identifying information are first removed.

Type or print name of legal representative (if applicable)

Date

Signature of patient or legal representative

Witness signature

Send completed forms to:

The Safety Net Foundation
P.O. Box 13185
La Jolla, CA 92039-3185
Phone: 888/SN-AMGEN (888/762-6436) Fax: 866/549-7239