

FORM C: PRODUCT REQUEST



Facility Name: _____

Shipping Address: _____

Sponsor Contact Name: _____
First/Last Name

The Safety Net Foundation
P.O. Box 13185

Customer Number: _____

Title: _____

La Jolla, CA 92039-3185

Fax Number: _____

Contact Phone Number: _____

Patient Last Name	Patient First Name	Date of Birth	Last 4 Digits of SSN (optional)	Product Name	Unit of Measure Vial/ Syringe/ Units	Vial / Syringe Strength	Quantity Vials/ Syringes / Units Dispensed	Admin Start Date	Admin End Date	Total Number of Administrations (Epoetin alfa Only)

Certification Statement

By signing and submitting this application, I agree to the following:

I certify that the Amgen product reported on this form, for which I am requesting free replacement, was furnished free of charge to the designated Safety Net Foundation patient. I represent that the information provided in this form is complete and accurate to the best of my knowledge and agree to notify The Safety Net Foundation of any changes I become aware of which could affect patient eligibility with The Safety Net Foundation. I further certify that I am authorized to act for the institution for which I am signing.

I understand that The Safety Net Foundation is available for outpatient use only. I certify that no replacement will be requested for product administered in the hospital inpatient setting.

I authorize this replacement order to be shipped to my office for in-facility use. I further authorize this replacement order to be shipped in single units as a prescription. I understand that in the event the signature below is not a physician's, The Safety Net Foundation will ship the closest wholesale quantity and credit any remaining balance to my facility's account.

The physician OR the sponsor contact may sign this form. One signature is sufficient. Both do not need to sign.

Physician Signature: _____
(Stamps not accepted)

Print Physician First Name / Last Name: _____

Physician State License Number: _____ Date: _____

Physician Email: _____

OR

Sponsor Contact Signature: _____
(Stamps not accepted)

Date: _____

Send completed forms to:
The Safety Net Foundation, P.O. Box 13185, La Jolla, CA 92039-3185
Tel: 1-888-SN-AMGEN (1-888-762-6436) Fax: 1-877-727-2867

Internal Processing Only
Date Received _____