

FORM A: SPONSOR ENROLLMENT FORM

Instructions: This form should be completed by a sponsoring facility or The Safety Net Foundation Specialist. This form only needs to be submitted once per sponsoring facility.

Sponsor (Facility) Mailing Information

Sponsor (Facility) Name: _____

Contact Person Name: _____

Title: _____

Facility Numbers: NPI: _____ DEA: _____ AHA: _____ HIN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Preferred Method of Written Contact (primary) – check only one: Email Postal Mail Fax

Preferred Method of Written Contact (secondary) – check only one: Email Postal Mail Fax

If your facility is part of a chain or group-purchasing organization, please list the name: _____

Please indicate if the sponsor is a:

_____ Physician Office	_____ Hospital	_____ Hospital Pharmacy
_____ Community Pharmacy	_____ Specialty Pharmacy	_____ Dialysis Center: Hospital-Based
_____ Home Dialysis Supplier	_____ Home Health Care	_____ Dialysis Center: Free-Standing
	_____ Transplant Center*	_____ Infusion Center

***The Safety Net Foundation cannot provide assistance for inpatient hospital use.
EPOGEN® Sponsors must be a physician office, hospital, dialysis center, home dialysis supplier, or transplant center.**

Third Party Administrator Information

If your facility uses a third party administrator (TPA) to facilitate processing for patient assistance programs, please indicate:

Company Name: _____

Contact Person _____

Title _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Email Address _____

Preferred Method of Written Communication (Primary) – check one Email Postal Mail Fax

Preferred Method of Written Communication (Secondary) – check one Email Postal Mail Fax

Sponsor Name _____

Pharmacy Director Information

If your facility has a Pharmacy Director, please list his/her name (*required for sponsors that use TPAs*):

Pharmacy Director Name: _____

Title _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Email Address _____

Preferred Method of Written Communication (Primary) – check one
 Email Postal Mail Fax

Preferred Method of Written Communication (Secondary) – check one
 Email Postal Mail Fax

Internal Use Only: The Safety Net Foundation Customer Number: _____

Sponsor (Facility) Product Shipping Information

Confirm address where product should be shipped (if different than mailing address).

Sponsor (Facility) Name: _____

Shipment Contact Person Name: _____

Title _____

Address _____

(*PO Box is not accepted*)

City _____ State _____ Zip _____

Telephone _____ Fax _____

SPONSOR CERTIFICATION AND CONSENT

Sponsor Name _____

By submitting this application, I agree to the following:

- I will provide Amgen products for patients in a medically appropriate manner based on current standards of medical care.
- I understand that The Safety Net Foundation reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen products under this program to any patient or sponsor.
- I understand that product is provided on a replacement basis. Participating providers are required to stock the product and apply for replacement product through The Safety Net Foundation.
- I understand that an insurance verification may be required to determine a patient's eligibility for The Safety Net Foundation.
- I understand that the product received through The Safety Net Foundation is for medically needy patients living in the United States and its territories.
- I certify that no third party or patient has been or will be charged for Amgen products for which replacement is sought under The Safety Net Foundation. I further certify that all product received in connection with The Safety Net Foundation will replace such product; be furnished free of charge for treatment of needy patients who meet The Safety Net Foundation criteria; and, that no part of any charges for Amgen products replaced under The Safety Net Foundation will be claimed as bad debt.
- 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 represent that the information contained in all patient applications under my sponsorship, including Form B will be complete and accurate to the best of my knowledge. If I become aware of any changes in the patient's circumstances that affect Safety Net Foundation eligibility, I agree to notify The Safety Net Foundation immediately.
- I agree to release or make available to an authorized Safety Net Foundation representative the medical and financial records for Safety Net Foundation patients at any time for the sole purpose of verifying patients' eligibility for The Safety Net Foundation, and I agree to obtain appropriate consent from each patient prior to releasing or making available to The Safety Net Foundation such records or information.
- I further certify that I am authorized to act for the institution for which I am signing.

Signature of Sponsor's Authorized Representative _____ Date: _____

Title _____

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