

PRODUCT REPLACEMENT ORDER FORM

Replacement Products	Aranesp® (darbepoetin alfa)	Nplate® (romiplostim)
	EPOGEN® (epoetin alfa) (for dialysis use only)	Prolia® (denosumab) injection (PMO & CTIBL use)
	Neulasta® (pegfilgrastim)	Vectibix® (panitumumab) injection
	NEUPOGEN® (Filgrastim)	XGEVA® (denosumab)

To order product replacement:

- **Complete** the Product Replacement Request Form in full
 - Ensure provider and patient are enrolled in the Foundation
 - All information on the form is required for processing
 - Multiple patients and products may be entered on a single form if the Facility Customer Number and Shipping Address are the same
- **Obtain** the appropriate provider signature
 - Either PHYSICIAN SIGNATURE to receive exact quantity or FACILITY CONTACT SIGNATURE to receive closest wholesale quantity

PRODUCT REPLACEMENT ORDER FORM

Use this form for replacement service model products only (Aranesp[®], EPOGEN[®] for dialysis use, Neulasta[®], NEUPOGEN[®], Nplate[®], Prolia[®] for bone health or CTIBL use, Vectibix[®] and XGEVA[®])

FACILITY & CONTACT INFORMATION

Facility Shipping Address	Facility Name:			Facility Customer Number:		
	Contact Name:		Contact Title:		Phone #: () -	Fax #: () -
	Street Address: _____ Street (PO BOX not accepted) _____ City _____ State _____ Zip _____					

PHYSICIAN, FACILITY & SHIPPING INFORMATION

PATIENT NAME (Last, First)	DATE OF BIRTH	PRODUCT NAME	UOM (Vial/ Syringe/Units)	STRENGTH (Vial / Syringe)	QUANTITY DISPENSED	ADMIN START DATE	ADMIN END DATE	TOTAL # ADMINS	if Aranesp [®]	
									PRESCRIBER NAME	PRESCRIBER SLN

✓ 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/prescription to be shipped to my office for in-facility use.

✓ **I understand that either the physician OR the facility contact may sign this form. However, in the event that 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.**

PHYSICIAN SIGNATURE (required to receive **exact quantity**)
Date: / /

PHYSICIAN NAME (first and last name/SLN)
SLN:

OR

FACILITY CONTACT SIGNATURE (under shipped to the closest **wholesale quantity**)
Date: / /

Fax completed form to (866) 549-7239