

**Form C: PRESCRIPTION FORM**

**Physician Instructions:** Please complete form and fax or mail the completed application packet (Form B, Form C, and income documentation) to the address below.

**To:** The Safety Net Foundation  
PO Box 13185  
La Jolla, CA 92039-3185  
Phone: 888-SN-AMGEN (888-762-6436) Fax: 800-981-6690

**From:** Physician Name: \_\_\_\_\_ DEA#: \_\_\_\_\_ *(Optional)*  
State License Number: \_\_\_\_\_ *(Required)* NPI# \_\_\_\_\_  
Physician Contact (other than physician): \_\_\_\_\_  
Facility/Practice Name: \_\_\_\_\_ CMA# \_\_\_\_\_  
Mailing Address (no PO boxes): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_  
Physician Email \_\_\_\_\_ Physician Contact Email \_\_\_\_\_  
Physician Preferred Method of Written Contact (primary) – check only one:  Email  Postal Mail  Fax  
Physician Preferred Method of Written Contact (secondary) – check only one:  Email  Postal Mail  Fax  
Shipping Address (if different than mailing): \_\_\_\_\_  
*(PO Box is not accepted)*  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email: \_\_\_\_\_  
For Nplate™ prescriptions, please complete the following:  
Nplate™ NEXUS Physician ID#: \_\_\_\_\_  
Nplate™ NEXUS Facility ID#: \_\_\_\_\_

**Patient Information**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Gender: \_\_\_\_\_  
Nplate™ NEXUS Patient ID#: (if applicable) \_\_\_\_\_ Nplate™ Patient dx (required for Nplate™): \_\_\_\_\_

**Prescribing Information**

**Physician Initials for Sensipar® Prescription:** \_\_\_\_\_

Medication	Dose	Frequency	Check One	Quantity
Sensipar®	30 mg	_____ daily		12 month supply (2-month supply per shipment)
Sensipar®	60 mg			
Sensipar®	90 mg			

**Physician Initials for Nplate™ Prescription:** \_\_\_\_\_

Medication	Dose	Frequency (weekly/monthly)	Check One	Quantity
Nplate™	250 mcg			
Nplate™	500 mcg			

I have prescribed the product indicated above for the referenced patient. My patient gave consent for me to provide this information. I understand that no third party or patient should be billed or charged for the product provided by this program. I understand that no free product should be sold, traded, or distributed for sale.

**X** \_\_\_\_\_  
**Physician's Original Signature** (stamps not accepted) Date

Completion of this form is part of the initial application process and does not guarantee enrollment in The Safety Net Foundation. The Foundation will review the completed application to determine the patient's eligibility.