The Safety Net Foundation

INSTITUTIONAL PATIENT ASSISTANCE PROGRAM FOR REPLACEMENT OF PHYSICIAN-ADMINISTERED PRODUCTS

INSTITUTIONAL PATIENT ASSISTANCE PROGRAM (PAP) PATIENT ENROLLMENT FORM INSTRUCTIONS

Thank you for your interest in applying to The Safety Net Foundation. The Foundation is a nonprofit organization that helps qualifying patients access Amgen medicines at no cost.

ELIGIBILITY GUIDELINES

- ✓ **Facility Enrollment:** Facilities must be enrolled as a Safety Net Foundation Institutional Patient Assistance Program facility.
- ✓ **Residence:** The patient must reside in the United States, Guam, Puerto Rico or the U.S. Virgin Islands
- ✓ **Insurance:** The patient must be uninsured
- ✓ **Income:** The patient's annual household income meets our program guidelines as follows:

Patient income guidelines for:	Number of people in household	Income must be at or below
ARANESP® (darbepoetin alfa) FOR NEPHROLOGY EPOGEN® (Epoetin alfa) (Filgrastim) PROLIA® (denosumab) injection	1	$41,195
	2	$55,755
	3	$70,315
	4	$84,875
	Each additional person	Add $14,560

Patient income guidelines for:	Number of people in household	Income must be at or below
ARANESP® (darbepoetin alfa) FOR ONCOLOGY NEULASTA® (pegfilgrastim) NEUPOGEN® (Filgrastim) NPLATE® (romiplostim) VECTIBIX® (panitumumab) XGEVA® (denosumab)	1	$58,850
	2	$79,650
	3	$100,450
	4	$121,250
	Each additional person	Add $20,800

HOW TO APPLY CHECKLIST

FOR THE PROVIDER:

- ☐ Complete the **PATIENT INFORMATION** section of the application
- ☐ Sign the **FACILITY CERTIFICATION AND AUTHORIZATION TO DISCLOSE INFORMATION**
- ☐ Complete the **PRODUCT INFORMATION** and **PHYSICIAN AND FACILITY INFORMATION** sections of the application
- ☐ Fax the completed application to (866) 549-7239.
- ☐ After product has been administered to the patient request replacement by completing and signing the **PRODUCT REPLACEMENT REQUEST FORM*.**

ONCE A DECISION HAS BEEN MADE, BOTH THE PATIENT AND PROVIDER WILL BE NOTIFIED. MISSING INFORMATION AND/OR INCOMPLETE APPLICATIONS WILL RESULT IN PROCESSING DELAYS.

***THIS FORM IS ALSO AVAILABLE FOR DOWNLOAD AT WWW.SAFETYNETFOUNDATION.COM**

The Safety Net Foundation

INSTITUTIONAL PATIENT ASSISTANCE PROGRAM FOR REPLACEMENT OF PHYSICIAN-ADMINISTERED PRODUCTS

PATIENT INFORMATION (MUST COMPLETE ALL SECTIONS)

Patient Name: _____ (Last) _____ (First) _____ (M.I.)

Date of Birth: ____-____-____ Social Security Number: ____-____-____ Sex: ☐ Male ☐ Female

Patient Mailing Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Patient Telephone: ____-____-____ ☐ Home ☐ Mobile ☐ Work ____-____-____ ☐ Home ☐ Mobile ☐ Work

FACILITY CERTIFICATION AND AUTHORIZATION TO DISCLOSE INFORMATION

The Safety Net Foundation ("the Foundation") is a nonprofit patient assistance program supported by Amgen that provides qualifying patients with Amgen products at no cost.

I certify that:

- ○ I am authorized to act for the institution for which I am signing.
- ○ I understand that the patient must meet the following eligibility criteria:
  - They have lived in the United States for six months or longer;
  - They are uninsured and are not pending any public or private insurance; and
  - Their annual household income meets the requirements set by the Foundation.
- ○ I understand that the Foundation is available for outpatient use only and I certify that no replacement will be requested for product administered in the hospital inpatient setting.
- ○ I will not charge or cause any other party to charge any third party or patient for Amgen products for which replacement is sought under the Foundation. I further certify that all product received in connection with the Foundation will be furnished free of charge for patients who meet the Foundation eligibility criteria, and, that no part of any charges for Amgen products replaced under the Foundation will be claimed as bad debt.
- ○ If I become aware of any changes in the patient's circumstances that affect their eligibility in the Foundation, I will notify the Foundation immediately.

I attest that I have written consent on file for this patient. This consent includes:

Authorization for the Foundation, Amgen, their agents, and third-party contractors or their service providers authorized to administer the Foundation to:

- ○ use the personal information provided on the Foundation application form to determine the patient's eligibility for and assist with the patient's continued participation in the Foundation;
- ○ contact the patient to seek feedback on the Foundation's services; and share information about the patient's medical condition, treatment, and health insurance coverage between the physician, healthcare professionals, health plan(s), care givers, and family members and the Foundation, Amgen, their agents, and third-party contractors or their service providers authorized to administer the Foundation.

Certification that:

- the patient's information provided on the application form is complete and accurate;
- the patient will not request reimbursement from any insurance carrier or government health benefit program for Amgen products that they receive from the Foundation.
- the patient will not sell, trade, or distribute Amgen products given to them by the Foundation.

The **understanding** that:

- completing the Foundation application form is not a guarantee of eligibility for the Foundation;
- the Foundation may change or discontinue the program at any time without notice;
- the patient may refuse to sign the patient consent, however if they refuse to sign or if they revoke their authorization, the patient will not be able to receive assistance from the Foundation;
- the patient's healthcare provider or insurers will not condition their medical treatment or insurance benefits on their agreement to the Foundation consent;
- once the patient's information is provided on the Foundation application form to the Foundation, Amgen, the agents, and third-party contractors or their service providers working on their behalf pursuant to this authorization, federal privacy laws may not prevent further disclosure of this information.

_____ Name of Facility's Authorized Representative

_____ Signature of Facility's Authorized Representative

_____ Date Signed

_____ Title of Facility's Authorized Representative

_____ Contact Phone Number of Facility's Authorized Representative

The Safety Net Foundation

INSTITUTIONAL PATIENT ASSISTANCE PROGRAM
FOR REPLACEMENT OF PHYSICIAN-ADMINISTERED PRODUCTS

Patient Last Name: _____ Patient First Name: _____ Patient Date of Birth: _____

FACILITY & PRESCRIBING PHYSICIAN INFORMATION (MUST COMPLETE ALL SECTIONS)
CHOOSE PRODUCT(S) COMPLETE THE PRODUCT REPLACEMENT REQUEST FORM AFTER ADMINISTRATION

- ☐ Aranesp® (darbepoetin alfa) for **Nephrology**
- ☐ Aranesp® (darbepoetin alfa) for **Oncology**
- ☐ Neulasta® (pegfilgrastim)
- ☐ Nplate® (romiplostim)
- ☐ Prolia® (denosumab) injection for **Oncology**
- ☐ XGEVA® (denosumab)
- ☐ EPOGEN® (epoetin alfa) for dialysis use only
  Is the patient currently on dialysis? ☐ **Yes** ☐ **No**
- ☐ NEUPOGEN® (Filgrastim)
- ☐ Prolia® (denosumab) injection for **Bone Health**
- ☐ Vectibix® (panitumumab) Injection

Facility Contact Detail	Facility Name:_____ Facility Contact First and Last Name: _____ Title: _____ Preferred Phone:_____- _____-_____ Preferred Fax:_____- _____-_____ Mailing Address: _____ _____ _____ _____ Street (PO BOX not accepted) City State Zip
Prescribing Physician	First Name:_____ Last Name:_____ Phone: _____- _____-_____ Fax : _____- _____-_____