The Safety Net Foundation

PATIENT ASSISTANT 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

- **Residence**: You must reside in the United States, Guam, Puerto Rico or the U.S. Virgin Islands.
- **Income**: You and your household member's combined Annual Adjusted Gross Income does not exceed our program guidelines.
- **Insurance**: You have no or limited coverage for the prescribed Amgen medication.

HOW TO APPLY

- **Patient:** Complete PATIENT INFORMATION (page 1 of application) and sign and date Patient Consent (page 2 of application)
- **Provider:** Complete PRODUCT INFORMATION (page 3 of application); and if prospective product ordered, complete the PRODUCT PRESCRIPTION FORM (page 4 of application) including signature and date
- **Provider:** FAX your completed application to **(866) 549-7239**

NEXT STEP

Once we receive your completed application, both you and your physician will be notified of your eligibility. For any questions, please call (888) 762-6436, Monday through Friday, 9am to 9pm Eastern Time.

The Safety Net Foundation

PATIENT APPLICANT INFORMATION

Patient Name:

Sex: ☐ Male ☐ Female

Last _____ First _____ M.I. ____

Date of Birth: / /

Social Security Number: - -

U.S. Resident: ☐ Yes ☐ No

Patient Address:

Street _____ City _____ State _____ Zip _____

Telephone:

( ) -

☐ Home ☐ Mobile ☐ Work

( ) -

☐ Home ☐ Mobile ☐ Work

Current Adjusted Gross Household Income: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly $.

Total Number of People Within Household (including yourself):

Are you enrolled in Medicaid? ☐ Yes ☐ No ☐ Emergency Only

Are you enrolled in Medicare? ☐ Yes ☐ No If Yes, Medicare ID #:

Are you enrolled in Medicare Part D? ☐ Yes ☐ No ☐ Pending

Do you have commercial insurance? ☐ Yes ☐ No ***If Yes, please complete below as applicable:***

PRIMARY Insurance	Insurer:	Phone #: ( ) -
	Subscriber Name:	Relationship to Patient:
	Policy Number:	Group Number:
SECONDARY Insurance	Insurer:	Phone #: ( ) -
	Subscriber Name:	Relationship to Patient:
	Policy Number:	Group Number:
PHARMACY Insurance	Insurer:	Phone #: ( ) -
	Subscriber Name:	Relationship to Patient:
	Policy Number:	Group Number:

Are you eligible for other federal, state, local government or charity care programs (VA/DOD)? ☐ Yes ☐ No ***If Yes, please complete below:***

OTHER	Program Name:	Policy Number:
	Effective Date: _____/_____/_____	Phone #: ( ) -

The Safety Net Foundation

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

- use the information that I provided on the Foundation application form to determine my eligibility for and assist with my continued participation in the Foundation.
- use my social security number to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process.
- contact me to seek feedback on the Foundation's services.

For these purposes, I also authorize the sharing of information about my medical condition, treatment, and health insurance coverage between my 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.

I certify that:

- the information I provided on the Foundation application form is complete and accurate.
- I will not request reimbursement from any insurance carrier or government health benefit program for Amgen Products that I receive from the Foundation.
- I will notify the Foundation within thirty (30) days if my financial status or health insurance coverage changes.
- I will not sell, trade, or distribute Amgen products given to me by the Foundation.

I understand 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.
- I may refuse to sign this form, but if I refuse to sign or revoke my authorization, I will not be able to receive assistance from the Foundation.
- my healthcare provider or insurers will not condition my medical treatment or insurance benefits on my agreement to sign this form.
- once I provide the information 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.
- I may receive a copy of this form or revoke it at any time by contacting the Foundation at 1-888-762-6436.
- this authorization will expire one (1) year after the date it is signed below or one (1) year after the last date I receive product from the Foundation, whichever is later.

Signature of patient or legal representative	**Print Name of patient or legal representative**	**Date Signed**

The Safety Net Foundation reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. The Safety Net Foundation also reserves the right to make an independent determination of financial need.

The Safety Net Foundation

PRODUCT INFORMATION

☐ Aranesp® (darbepoetin alfa)	Therapeutic Area: ☐ Nephrology ☐ Oncology
☐ EPOGEN® (epoetin alfa)	Is patient currently on dialysis? ☐ Yes ☐ No First date of dialysis: / /
☐ Neulasta® (pegfilgrastim)	
☐ NEUPOGEN® (Filgrastim)	
☐ Nplate® (romiplostim)	
☐ Prolia® (denosumab) Injection	Therapeutic Area: ☐ Bone Health ☐ Oncology
☐ Sensipar® (cinacalcet) Tablets	
☐ Vectibix® (panitumumab) Injection	
☐ XGEVA® (denosumab)	

PHYSICIAN, FACILITY & SHIPPING INFORMATION

Physician	First Name:	Last Name:
	Phone #: ( ) -	Fax #: ( ) -
Facility Mailing Address	Facility Name:	
	Contact Person First Name:	Contact Person Last Name:
	Phone #: ( ) -	Fax #: ( ) -
	Street Address: _____ (Street (**PO BOX not accepted**)) _____ (City) _____ (State) _____ (Zip)	

Is the Facility "Ship To" address the same as the Facility mailing address? ☐ Yes ☐ No ***If No, please provide correct shipping address below:***

Facility Shipping Address	Ship To Facility Name:	
	Contact Person First Name:	Contact Person Last Name:
	Phone #: ( ) -	Fax #: ( ) -
	Street Address: _____ (Street (**PO BOX not accepted**)) _____ (City) _____ (State) _____ (Zip)	

The Safety Net Foundation

PRODUCT PRESCRIPTION FORM

Use this form for Prospective products only (Sensipar® (cinacalcet) and Prolia® (denosumab) Injection for Bone Health use)

NOTE: Use the Product Replacement Order Form for Replacement products (Aranesp®, EPOGEN® for dialysis use, Neulasta®, NEUPOGEN®, Nplate®, Prolia® for bone health or CTIBL use, Vectibix®, and XGEVA®)

Patient

Patient Name:	Sex:	Date of Birth:
_____ LAST _____ FIRST	☐ Male ☐ Female	/ /

Physician

First Name:	Last Name:	State License # :
Phone # : ( ) -	Fax # : ( ) -	
Street Address: _____ Street (**PO BOX not accepted**) _____ City _____ State _____ Zip		

Facility/ Practice

Facility/Practice Name:	Facility/Practice Contact Name: (other than physician)

PRESCRIPTION (Prospective Products Only)

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
Prolia® (denosumab) Injection for Bone Health	☐ 60 mg Pre-filled syringe ☐ _____			☐ 1 year or ☐ x ____
Sensipar® (cinacalcet) Tablets ☐ *Ship to patient* ☐ *Ship to office*	☐ 30 mg ☐ 90 mg ☐ 60 mg ☐ _____		2 month supply	☐ 1 year or ☐ x ____
SHIPMENT INSTRUCTIONS:	Prolia® is shipped directly to the provider. Sensipar® may be shipped directly to the patient if indicated above.			

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.

Physician's Original Signature (stamps not accepted) _____ **Date Signed**

Completion of this form is independent of the application process and does not guarantee enrollment in The Safety Net Foundation. The Safety Net Foundation must review the complete application to determine the patient's eligibility.

➢ FAX this completed product prescription form to **(866) 549-7239**