AMGEN Safety Net Foundation

Amgen Safety Net Foundation is a nonprofit patient assistance program that helps qualifying patients access Amgen medicines at no cost.

Are you eligible?

Apply for support if you meet the following requirements:

- **You have lived in the United States, American Samoa, Guam, Puerto Rico, or the U.S. Virgin Islands for six months or longer.**
- **You have a household income at or below:**
  $45,180 .....for a household of 1 person
  $61,320 .....for a household of 2 people
  Add $16,140 for each extra person
- **You are uninsured or your insurance plan excludes the Amgen medicine or its generic/biosimilar.**
- **Certain Medicare Part D patients with coverage for the Amgen medicine who cannot afford their out of pocket costs may be eligible. It is required that you are able to demonstrate:**
  - Your inability to afford the medicine
  - Your ineligibility for Medicaid or Medicare's low-income subsidy (Extra Help)
  - You have satisfied all payer guidelines and Prior Authorization (PA) requirements prior to applying for assistance
  - You do not have any other financial support options

Questions?

Contact us at **1-800-932-3060**, Monday through Friday 8am to 8pm Eastern Time.

Prior to applying

- If you are insured, contact your healthcare plan to understand your medicine coverage.
- If you have been denied coverage for the Amgen medicine (0% coverage) you must exhaust the maximum coverage appeals allowed by your healthcare plan, and submit this support documentation.
- If you have Medicare Part D, submit support documentation stating that an active Prior Authorization (PA) has been filed with your healthcare plan.
- If you are a low-income patient, apply to your local Medicaid office for healthcare insurance and where applicable, Medicare's low-income subsidy (Extra Help). If denied, submit this support documentation.

How to apply

STEP 1 Complete all sections of the **PATIENT APPLICATION** (pages 1-4). Applications missing required information cannot be processed.

STEP 2 Have your physician fill out the **PRESCRIPTION** (page 5).

STEP 3 Have your prescribing physician fax the completed application and prescription to: **1-833-959-1409**.

Please keep this page for your records. Do not fax or send this page back.

What happens after I apply?

You and your physician will both be notified once a decision is made. If you are approved, you will be contacted by a Patient Assistance Counselor to obtain your consent to schedule a shipment of your Amgen medicine.

PATIENT INFORMATION Please PRINT all information on this form legibly

F5

Enrollment form for Corlanor® (ivabradine) tablets

1. Your info

Last name _____ First name _____ Middle initial _____

◯ **Male** ◯ **Female** Date of birth ____ (MM) / ____ (DD) / ____ (YYYY) Social Security Number ____ - ____ - ____

Address _____ City _____ State _____ Zip _____

Preferred telephone ____ - ____ - ____ ◯ **Home** ◯ **Mobile** ◯ **Work** I agree to receive messages via phone and ◯ **Text** ◯ **Email**

Alternate telephone ____ - ____ - ____ ◯ **Home** ◯ **Mobile** ◯ **Work** Preferred language ◯ **English** ◯ **Spanish** ◯ **Other** _____

Email _____ Other authorized contact _____

2. Where you live

You have lived in the U.S. or its territories (American Samoa, Guam, Puerto Rico, or U.S. Virgin Islands): ◯ **Greater than 6 months** ◯ **Less than 6 months**

3. Your income

My household makes $ _____ **annually** prior to taxes being withheld. Include all individuals in your household. Include wages, Social Security, Social Security disability, unemployment, pensions, and any other income. You may be asked to provide proof of income.

How many people live in your household (including yourself)? ◯ **1** ◯ **2** ◯ **3** ◯ **4** ◯ **Other** _____

Your household size includes all individuals you reported on your U.S. Tax Return. If you did not file a tax return please include all individuals that live with you.

◯ **Yes** ◯ **No** Are your combined savings, investments and real estate worth more than **$33,950** if you are married and living with your spouse; or worth more than **$17,010** if you are not married or not living with your spouse? Do NOT count your home, vehicles, personal possessions, life insurance, burial plots, irrevocable burial contracts or back payments from Social Security or SSI.

4. Your eligibility for government programs

Please include an enlarged copy of your insurance cards (front & back)

Medicare

◯ **Yes** ◯ **No** ◯ **Pending** Do you have Medicare? **Medicare ID#** It is on the front of your Medicare Card __ __ __ __-__ __ __-__ __ __ __

Medicare effective date ____ / ____ / ____ (MM/DD/YYYY)

◯ **Yes** ◯ **No** ◯ **Pending** Do you have Medicare Part D?

If you have Medicare Part D and have applied for Medicare's Low Income Subsidy (Extra Help), which of the following decisions did you receive?
◯ **Full support** ◯ **Partial support** ◯ **Denied** ◯ **Did not apply**

Medicaid

◯ **Yes** ◯ **No** Do you have Medicaid?

Other

◯ **Yes** ◯ **No** Are you eligible for or enrolled in any federal, state, or local healthcare programs? Including VA, DoD, or IHS.

5. Your insurance

Select the statement that applies to your insurance status:

◯ **I do not have health insurance.**
◯ **I have health insurance (e.g. Commercial, Medicare, Medicaid) but the Amgen medicine or its generic/biosimilar is NOT covered.** You must complete Section 5.
◯ **I have Medicare Part D and cannot afford my high out-of-pocket cost.** You must complete Section 5.

Your primary medical insurance
Healthcare Coverage, Medicare, or Medicaid

Type ◯ **Medicare Advantage** ◯ **Medicare A/B** ◯ **Medicaid** ◯ **Commercial** ◯ **Other** _____

Insurance/Payer _____ Plan name _____ Plan phone # ____ - ____ - ____

Subscriber name _____ Relationship to patient _____ DOB ____ (MM) / ____ (DD) / ____ (YYYY)

Member ID/policy # __ __ __ __-__ __ __-__ __ __ __ Group # _____

Your pharmacy insurance
Prescription Coverage or Medicare Part D

Type ◯ **Medicare Advantage** ◯ **Medicare Part D** ◯ **Medicaid** ◯ **Commercial** ◯ **Other** _____

Insurance/Payer _____ Plan name _____

Plan phone # ____ - ____ - ____ PCN # _____ BIN # _____

Subscriber name _____ Relationship to patient _____

Member ID/policy # _____ Group # _____

Plan year start date (MM/DD/YYYY) ____ / ____ / ____ Plan year end date (MM/DD/YYYY) ____ / ____ / ____

Your physician's information

Facility/Practice name _____ Clinic contact _____

Last name _____ First name _____ Phone # ____ - ____ - ____

Address _____ (STREET) (CITY) (STATE) (ZIP) Fax # ____ - ____ - ____

PATIENT CERTIFICATION AND AUTHORIZATION

Amgen Safety Net Foundation "the Foundation" is a nonprofit patient assistance program that helps qualifying patients access Amgen medicines at no cost.

Patient Certification

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 medications that I receive from the Foundation.
- I will notify the Foundation within thirty (30) days if my financial status or health insurance coverage changes.
- If I decide to enroll in a Medicare Part D plan, I will inform the Foundation at the number below prior to enrolling. If I receive notice that I have "auto-enrolled" in a Medicare Part D plan, I will immediately inform the Foundation.
- I will not sell, trade, or distribute Amgen medications given to me by the Foundation.

I understand that completing the Foundation application form is not a guarantee of eligibility for the Foundation. I also understand that the Foundation may change or discontinue the program at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year. I understand that if I am currently enrolled in a Medicare part D plan, I cannot utilize my Part D plan benefits for medications received through the Foundation for the duration of my enrollment in the Foundation.

Any medication I receive through the Foundation will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D. The Foundation reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen medications under this program to any patient or facility.

Fair Credit Reporting Act (FCRA) Authorization

I am providing written instructions authorizing the Foundation and its vendor to obtain my consumer report from a consumer reporting agency to be used solely for the eligibility determination process for programs administered by the Foundation.

The Foundation is not a state or federally funded program. The Foundation is sponsored solely by Amgen Inc.
The Foundation does not charge patients a fee for its assistance. The Foundation is not affiliated with third parties who charge a fee for assistance with enrollment or medication refills. If you are being charged a monthly fee for support from the Foundation, the organization billing you is not the Foundation and you are being charged for support that the Foundation can provide to you directly at no cost.

THIS FORM REQUIRES A PATIENT'S PRINTED NAME, SIGNATURE AND DATE OF SIGNATURE IN ORDER FOR THE FOUNDATION TO BEGIN PROCESSING THE APPLICATION

Printed name of patient _____

Printed name of legal guardian (if applicable) _____

Signature of patient (or legal guardian) _____

Dated MM/DD/YYYY _____

Please proceed to the next page.

Patient Authorization

I authorize the Foundation and its contractors and business partners to use and/or disclose my personal information, including my personal health information, for the following purposes:

- To determine my eligibility for and assist with my continued participation in the Foundation.
- To contact me to seek feedback on the Foundation's services.

In order for the Foundation to provide me with the services described above, the Foundation needs to collect and use my personal information, *including my personal health information*. I understand that my personal health information may include any information, in electronic or physical form, in the possession of or derived from a health care provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor ("Health Care Provider"). This may include information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I also authorize and instruct my Health Care Provider(s) to disclose my personal health information to the Foundation, and its contractors and business partners, for the purposes stated above.

I understand that I may refuse to sign this form, but if I refuse to sign it or revoke my authorization, I will not be able to receive assistance from the Foundation. I understand that signing this form is not a condition for receiving any medical care and that my Health Care Provider is not to condition my medical treatment or insurance benefits on my agreement to sign this form.

I understand that once I provide my personal information to the Foundation, and its contractors and business partners, or once my Health Care Provider has provided my personal information to the Foundation, and its contractors and business partners, pursuant to this authorization, federal privacy laws (including HIPAA) may not prevent redisclosure of this information; however, the Foundation, and its contractors and business partners, has agreed to protect my personal information by using and disclosing it only for the purposes described above or as required by law.

I understand that I may receive a copy of this form at any time by contacting the Foundation at 1-800-932-3060 and I may revoke my authorization by mailing a revocation to PO Box 19149, Lenexa, KS 66285. A revocation must be in writing and is not effective to the extent that action has already been taken based on this authorization.

I understand that this authorization will expire two (2) years after the date it is signed below or one (1) year after the last date I receive medication from the Foundation, whichever is later.

I understand and consent to the Foundation contacting me using the contact information provided to enroll me in, operate, and administer the services as described above. I understand that the operation and administration of certain of these services may require that the Foundation contact me by telephone or SMS/text.

THIS FORM REQUIRES A PATIENT'S PRINTED NAME, SIGNATURE AND DATE OF SIGNATURE IN ORDER FOR THE FOUNDATION TO BEGIN PROCESSING THE APPLICATION

Printed name of patient

Printed name of legal guardian (if applicable)

Signature of patient (or legal guardian)

Dated MM/DD/YYYY

By signing above, I am indicating that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal guardian for the Foundation and its contractors and business partners to use and share the personal information I provide for the purposes described within the Authorization above.

Please proceed to the next page.

U.S. STATE LAW CONSENT TO PROCESS HEALTH DATA

Consent to Health Data Processing for the Foundation

I consent to the Foundation processing my Health Data for the following purposes:

- To determine my eligibility for and assist with my continued participation in the Foundation.
- To contact me to seek feedback on the Foundation's services.

The Foundation uses the following when it administers the program:

- Health Data – your name (and the name of your caregiver if applicable), gender, date of birth, contact information and information relating to your health condition or treatment.

I understand that my consent to processing is required for me to participate in the program. I also understand that the Foundation will not sell my Health Data to third parties, but the Foundation may disclose my Health Data to the Foundation's data processors, contractors, and business partners for the Foundation's business purposes related to the program. I understand that the Foundation may use my Health Data to contact me by mail, email, or telephone for the above purposes. I also understand that if I do not consent to the use of my Health Data for the above purposes, I will not be able to participate in the program. Finally, I understand that I may obtain a copy of this consent form or withdraw my consent to the collection, processing and/or disclosure of my Health Data for the above purposes at any time by calling 1-800-932-3060 or by mailing a revocation to PO Box 19149, Lenexa, KS 66285, and that if I withdraw my consent, I will no longer be able to participate in the program.

THIS FORM REQUIRES A PATIENT'S PRINTED NAME, SIGNATURE AND DATE OF SIGNATURE IN ORDER FOR THE FOUNDATION TO BEGIN PROCESSING THE APPLICATION

Printed name of patient

Printed name of legal guardian (if applicable)

Signature of patient (or legal guardian)

Dated MM/DD/YYYY

By signing above, I am indicating that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal guardian for the Foundation to collect, process and disclose my Health Data I provide for the purposes described within the Consent above.

AMGEN Safety Net Foundation

This page must be completed and faxed by your prescribing physician. Prescribing physician signature attesting to consent is required on this application (bottom of page) but an original prescription is also accepted in place of the prescription section on this form.

Patient name _____ (Last name) _____ (First name)

Sex: ◯ **Male** ◯ **Female** Date of birth MM/DD/YYYY ____ / ____ / ____ Phone # ____ - ____ - ____

Known drug allergies Required entry. If no known drug allergies, check None. ◯ **None** ◯ **Attached** ◯ **Allergies**: _____

Concurrent medications Required entry. If no known concurrent medications, check None. ◯ **None** ◯ **Attached** ◯ **Medications**: _____

Medication **Corlanor**® (ivabradine) tablets

Dose	Frequency	Dispense Amount	Refills	Patient Diagnosis Code
☐ 5 mg ☐ 7.5 mg ☐ _____	☐ Twice daily ☐ _____	☐ 90 days	☐ 1 year or ☐ x _____	ICD-10 required if patient has insurance ICD-10 _____

☐ **Electronic Prescription (eRX) Submitted** MedVantx NPI number: **1073692745** NCPDP number: **4351968**
NY State Prescribers must also submit an ePrescription or phone in the prescription.

Facility/Practice name _____

Street address _____ (Street (PO Box not accepted)) _____ (City) _____ (State) _____ (Zip)

Clinic contact _____ Phone ____ - ____ - ____ Fax ____ - ____ - ____

Prescribing physician name _____ (Last name) _____ (First name)

National Provider ID (NPI) _____ Tax ID _____ Both IDs required

Prescribing physician state license number _____

I have prescribed the Amgen medicine indicated above for the referenced patient. My patient gave consent for me to provide this information. I understand that no third party or patient may be billed or charged for the Amgen medicine provided by this program. I understand that no medication received from Amgen Safety Net Foundation may be sold, traded, or distributed for sale.

Prescribing physician's signature Stamps not accepted _____ **Date signed** MM/DD/YYYY

This form must be completed and submitted with the patient application but does not guarantee enrollment in or fulfillment of this prescription by the Amgen Safety Net Foundation. Amgen Safety Net Foundation must review the complete application including this prescription or an original script to determine the patient's eligibility.

Fax this prescription to 1-833-959-1409