

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). 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 # _____

Medication ENBREL® (etanercept)

Dose	Frequency	Dispense Amount	Refills	Patient Diagnosis Code <small>ICD-10 required if patient has insurance</small>
One ENBREL 50 mg SureClick® One ENBREL 50 mg pre-filled syringe One ENBREL 25 mg vial One ENBREL 25 mg pre-filled syringe One ENBREL 50 mg Mini™ _____	Once weekly Twice weekly Twice weekly for 3 months; then once weekly _____	90 days _____	1 year or x _____	ICD-10 _____

Electronic Prescription (eRX) Submitted Pharmacy NPI: **1336325265** NCPDP number: **3989603**
 NY State Prescribers must also submit an ePrescription or phone in the prescription.

Facility/Practice name _____

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

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