AMGEN Safety Net Foundation

REPLACEMENT REQUEST

Amgen Safety Net Foundation offers replacements for physician-administered medications. Under this model, physicians administer Amgen medicines from their existing commercial stock to enrolled Foundation patients and then requests replacement for this medicine from the Foundation.

Request guidelines

- The patient must be enrolled in the Foundation.
- Requests for dates of administration in the future cannot be processed.
- Outpatient medication administration record must be submitted with this form.*
- Replacement medicine may be requested for dates of administration up to six months prior to the patient's enrollment start date.
- Requests must be for the exact Amgen medicine, quantity, unit of measure, strength, and administration dates as what is recorded in the outpatient administration record.
- Requests are not valid unless a licensed physician authorized to act for the facility or institution has initialed each line of the attestation and has signed the completed request.
- Amgen Safety Net Foundation is available for outpatient use only. Amgen Safety Net Foundation does not provide support for medicine administered in a hospital inpatient setting.
- The Amgen medicines requested on this form must have been furnished at no cost to an enrolled Amgen Safety Net Foundation patient and no charges were made to or through a third party or the patient for which replacement has been requested. Medication replaced by Amgen Safety Net Foundation may not be claimed as bad debt.
- Approved requests are shipped on a monthly basis directly to the facility address where the medication was administered as recorded on the outpatient administration record.

*** FOR BLINCYTO ONLY:** Outpatient medication or home health administration record must be submitted with this form regardless of site of service.

Administration Records Support Guidelines

- Administration records supporting documentation must include the following:
  - Must have the brand name drug listed
  - Patient full name and date of birth
  - Administered dose
  - Administered date/time
  - Administered by (Healthcare Provider Professional)
  - If hand-written Administration Records form is provided, signature is also required of the person who administered it.

What to expect next

- Once your order ships, a shipping slip will be included inside the box and a manifest will be faxed to your facility. This manifest contains your shipment's tracking number.
- New facilities will receive a welcome letter which will contain the ASNF facility customer number along with other pertinent information. The welcome letter will be faxed after this form is received using the contact information provided.
- Most facility shipments will be scheduled once a month on a set delivery day. Deliveries are scheduled Tuesday–Thursday only.

Submitting your request

Fax this completed request to: **1-844-465-1384**.
All information on this request is required. Failure to complete all information will result in processing and shipment delays.

***For IMLYGIC® only:**
IMLYGIC® must be stored at -80C° in an ultra-low freezer.

Aranesp® (darbepoetin alfa)
AVSOLA™ (infliximab-axxq)
BLINCYTO® (blinatumomab)
EPOGEN® (epoetin alfa) for dialysis use only
EVENITY™ (romosozumab-aqqg)
IMLYGIC® (talimogene laherparepvec)
KANJINTI™ (trastuzumab-anns)
Kyprolis® (carfilzomib)
MVASI™ (bevacizumab-awwb)
Neulasta® (pegfilgrastim)
NEUPOGEN® (filgrastim)
Nplate® (romiplostim)
Parsabiv™ (etelcalcetide)
Prolia® (denosumab) injection
RIABNI™ (rituximab-arrx)
Vectibix® (panitumumab) injection
XGEVA® (denosumab)

Please note:
Damages or quantity discrepancies must be reported within 24 hours of product delivery by calling 1-888-401-4931.

AMGEN Safety Net Foundation

Multiple patients and products may be entered on a single request if the facility customer number and shipping address are the same.

REPLACEMENT REQUEST

1. Facility Information

Shipping address must be the same as the address where the Amgen medication was administered.

Facility name _____ **ASNF Facility Customer Number** _____

Required to verify facility. This can be found on your last shipping slip, manifest or by calling 1-888-401-4931. New facilities will receive a customer number after this form is submitted.

Facility contact name _____ (First) _____ (Last) **Title** _____ **Phone** ___-___-___ **Fax** ___-___-___

Shipping address _____ (Street (PO BOX not accepted)) _____ (City) _____ (State) _____ (ZIP) **HIN** _____ **DEA** _____

2. Patient Information

Patient name Last, First	**Patient date of birth** MM/DD/YYYY	**Amgen medicine administered**	**UOM** Kit, vial, syringe, unit	**Strength**	**Quantity dispensed**	**Administration start date** MM/DD/YYYY	**Administration end date** MM/DD/YYYY

Dates of administration must be in the past

3. Prescribing Physician Required to Initial Each Line

THIS FORM MUST BE COMPLETED PRIOR TO COMPLETION OF PHYSICIAN ATTESTATION AND SIGNATURE

_____ I represent that the information provided in this form is complete and accurate to the best of my knowledge and agree to notify Amgen Safety Net Foundation of any changes I become aware of which could affect patient eligibility with Amgen Safety Net Foundation. I further certify that I am authorized to act for the facility or institution for which I am signing.

_____ I certify that the administered Amgen medicine reported on this form, for which I am requesting free replacement, was furnished at no cost to the designated and enrolled Amgen Safety Net Foundation patient. I further certify that I will not charge or cause any other party to charge any third party or the patient for Amgen medicines for which replacement is sought under Amgen Safety Net Foundation and that no part of any charges for Amgen medicines replaced under Amgen Safety Net Foundation will be claimed as bad debt. I understand that my facility will be held financially responsible should any Amgen medicines be requested and received for patients found to be ineligible.

_____ I certify the above shipping address is valid and understand the facilities' shipments will be shipped based on the provided information.

_____ I understand our facility may be contacted to verify shipping information in certain situations and if contacted the order will not be shipped and will be placed on a hold until our facility confirms the needed shipping information. I understand that if our facility fails to provide the needed shipping information within 60 days of the request, the order will be cancelled.

_____ I attest that the patients for whom I am requesting replacement has no insurance coverage for the requested Amgen medicine, including Medicare that covers the requested Amgen medicine.

_____ I certify that any product received from the Foundation that is not used to treat the patient will be returned to the Foundation or my facility will reimburse the Foundation at the current Wholesale Acquisition Cost (WAC) value.

_____ I certify that the replacement medicine requested is for the same Amgen medicine, unit of measure, strength, and administration dates as what was recorded and I have attached the outpatient medication administration record.

_____ I understand that Amgen Safety Net Foundation is available for outpatient use only and no replacement was requested for medicine administered in the hospital inpatient setting.

_____ I authorize this replacement request/prescription to be shipped to my office for in-facility use.

_____ I understand that to ensure Amgen Safety Net Foundation requirements are met, the Foundation reserves the right to place a facility on hold to verify that only eligible patients received medicine. Amgen Safety Net Foundation may perform a physical audit of appropriate records (including patient records) at the facility with a 30-day advance notice, and/or withdraw any patient or facility from further participation in the Amgen Safety Net Foundation.

Physician signature Stamps not accepted _____ **Date signed** MM/DD/YYYY _____ **Printed first name** _____ **Printed last name** _____ **Physician state license number** _____