

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:**
 \$63,800 for a household of 1 person
 \$86,200 for a household of 2 people
Add \$22,400 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 **1-888-762-6436**, 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: **1-866-549-7239**.

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.

1. Which medicines have you been prescribed?

Corlanor® (ivabradine) Enbrel® (etanercept) Prolia® (denosumab) for Bone Health Repatha® (evolocumab) Sensipar® (cinacalcet)
 Are you on dialysis? Yes No

2. Your info

Last name _____ First name _____ Middle initial _____

Male Female Date of birth ____/____/____ Social Security Number ____ - ____ - ____

Address _____ City _____ State _____ Zip _____

Preferred telephone ____ - ____ - ____ Home Mobile Work Best time to call Morning Afternoon

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

Email _____ By providing your phone number and email, you allow us to contact you to complete the application process.

3. Where you live

Select only what applies Are you a: U.S. citizen Resident alien living in the U.S. for 10 years or longer Neither

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

You have lived in your current state: Greater than 6 months Less than 6 months

4. Your income

My household makes \$ _____ monthly annually Your gross income includes all individuals in your household. This includes 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 \$28,720 if you are married and living with your spouse; or worth more than \$14,390 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.

5. Your eligibility for government programs

Medicare	Yes No Pending Do you have Medicare? If you said yes, write your Medicare Effective Date here: ____/____/____ It is on the front of your Medicare Card.			
	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? <table border="1"> <tr> <td>Full support</td> <td>Partial support</td> <td>Denied</td> <td>Did not apply</td> </tr> </table>	Full support	Partial support	Denied
Full support	Partial support	Denied	Did not apply	
Medicaid	Yes No Do you have Medicaid?	Yes No N/A Are you pregnant?		
	Yes No If yes, is it Emergency Medicaid? Provide your Medicaid insurance information even if you only have Emergency Medicaid.	Yes No Are you legally blind or have you received a Social Security Disability status?		
	Yes No Have you been denied Medicaid? If yes, submit your recent Medicaid denial letter with this application (within the last 12 months).	Yes No Do you receive Social Security Disability?		
	Yes No Are you eligible for or enrolled in any federal, state, or local healthcare programs? Including VA, DoD, or IHS	Yes No Are you a parent or caretaker relative of a child under the age of 18?		
Other	Yes No Are you eligible for or enrolled in any federal, state, or local healthcare programs? Including VA, DoD, or IHS			

6. Your insurance

Select the statement that applies to your insurance status:

I do not have health insurance. You may skip Section 6.

I have health insurance (e.g. Commercial, Medicare, Medicaid) but the Amgen medicine or its generic/biosimilar is NOT covered. You must complete Section 6.

I have Medicare Part D and cannot afford my high out-of-pocket cost. You must complete Section 6.

Your primary insurance Healthcare Coverage, Medicare, or Medicaid	Insurer name _____ Plan name _____ Plan phone # ____ - ____ - ____
	Subscriber name _____ Relationship to patient _____ DOB ____/____/____
	Member ID/policy # _____ Group # _____
Your pharmacy insurance Prescription Coverage or Medicare Part D	Insurer name _____ Plan name _____
	Plan phone # ____ - ____ - ____ PCN # _____ BIN # _____
	Subscriber name _____ Relationship to patient _____
	Member ID/policy # _____ Group # _____
Your physician's information	Last name _____ First name _____ Phone # ____ - ____ - ____
	Address _____ State _____ Zip _____

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 Amgen Safety Net Foundation for the duration of my enrollment in the Foundation.

Any medication I receive through Amgen Safety Net 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.

Amgen Safety Net Foundation is not a state or federally funded program. The Foundation is sponsored solely by Amgen Inc.

Amgen Safety Net Foundation does not charge patients a fee for its assistance. Amgen Safety Net 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 Amgen Safety Net Foundation, the organization billing you is not the Amgen Safety Net Foundation and you are being charged for support that the Amgen Safety Net 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

Name of legal guardian (if needed)

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.

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 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 outside of the Foundation assistance and that my Health Care Provider will not 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, or my Health Care Provider has provided my personal information to the Foundation pursuant to this authorization, federal privacy laws (including HIPAA) may not prevent redisclosure of this information; however, the Foundation 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 1-888-762-6436 and I may revoke it by mailing a revocation to PO Box 18769, Louisville, KY 40261-7821. 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 one (1) year after the date it is signed below or one (1) year after the last date I receive medication from the Foundation, whichever is later.

By providing my phone number I authorize the Foundation to contact me by phone through the use of automated dialing machines and artificial or prerecorded messages for the purposes described above. I understand that these communications may discuss Amgen medications and I authorize the Foundation to leave voicemail messages.

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

Name of legal guardian (if needed)

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.

**UNINSURED ATTESTATION FORM
LOSS OF INCOME**

During this unprecedented and challenging time, the Amgen Safety Net Foundation (ASNF) remains focused on our commitment to provide access to Amgen medicines to qualifying U.S. patients. The novel coronavirus (COVID-19) caused major disruptions and changes in our everyday lives, which may include a change in income or job loss. Recognizing there may be immediate need for access to Amgen therapies, there is no requirement at this time to provide supporting records to verify income or insurance changes.

Lastname _____ **Firstname** _____ **Middle initial** _____

Address _____

City _____ **State** _____ **Zip** _____

Household size _____ **Estimated income (annual) \$** _____

I recognize that the information provided on this form will only be used for purposes of eligibility determination for my application to the ASNF. The ASNF will keep this information private, as required by federal law.

I attest that as a result of the COVID-19 crisis, my household size and income meet the below criteria:

Household of 1	\$63,800
Household of 2	\$86,200
Household of 3	\$108,600
Household of 4	\$131,000
<i>*Add \$22,400 for each extra person</i>	

Signature

Dated MM/DD/YYYY

Completed forms can be submitted to:

Fax 1-866-549-7239	Mail PO Box 18769 Louisville, KY 40261-7821
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Give this page to your prescribing physician to complete and fax along with your completed application. An original prescription is also accepted in place of this form.

Patient

Patient name _____
Last First

Sex: **Male** **Female** Date of birth MM/DD/YYYY ____ / ____ / ____ Is the patient allergic to latex? **Yes** **No**

Known drug allergies _____ Concurrent medications _____

Medication	Medication Dose	Frequency	Dispense Amount	Refills	Patient Diagnosis Code <small>ICD-10 required if patient has insurance</small>
Prolia® (denosumab) injection for Bone Health <small>Shipped directly to the physician</small>	60 mg pre-filled syringe _____	_____	_____	1 year or x _____	ICD-10 _____
Repatha® (evolocumab) injection	140 mg SureClick® 420 mg Pushtronex™ _____	Once every 2 weeks _____	12-week supply _____	1 year or x _____	ICD-10 _____
<small>New Enrollees: Repatha® is shipped monthly for the first 3 months, then every 3 months for the remaining number of refills.</small>					
Sensipar® (cinacalcet) tablets	30 mg 90 mg 60 mg _____	_____	2-month supply	1 year or x _____	ICD-10 _____
Enbrel® (etanercept)	50 mg SureClick® 50 mg pre-filled syringe 25 mg vial 25 mg pre-filled syringe 50 mg Mini™ _____	Once weekly Twice weekly Twice weekly for 3 months; then once weekly _____	12-week supply ____-week supply	1 year or x _____	ICD-10 _____
<small>New Enrollees: ENBREL® is shipped monthly for the first 3 months, then every 3 months for the remaining number of refills.</small>					
Corlanor® (ivabradine) tablets	5 mg 7.5 mg _____	_____	2-month supply	1 year or x _____	ICD-10 _____

Facility/Practice

Facility/Practice name _____ Contact name _____

Phone _____ - _____ - _____ Fax _____ - _____ - _____ All communications will be sent to this fax number.

Prescribing Physician

Prescribing physician name _____
Last First

Phone _____ - _____ - _____

Street address _____
Street (PO BOX not accepted) City State ZIP

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

Provider Transaction Access Number (PTAN) Required if the patient has Medicare _____

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 State license number _____ required 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.