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:**
  $64,400 .... for a household of 1 person
  $87,100 .... for a household of 2 people
  Add $22,700 for each extra person. You may be asked to provide proof of income in order to determine eligibility.
- **Your assets are valued at less than $29,250 (if you are married, living with spouse) or $14,960 (if you are not married or living with spouse)** *Assets include combined savings, investments and real estate combined, but do not include home, vehicles, personal possessions, life insurance, burial plots, irrevocable burial contracts or back payments from Social Security or SSI.*
- **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.

PATIENT INSTRUCTIONS

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 final denied determination letter with your application.
- If you have Medicare Part D, submit your final determination letter from your insurance stating that an active Prior Authorization (PA) is on file 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 supporting documentation.

How to apply

STEP 1 Complete all sections of the **PATIENT APPLICATION** (pages 1–4). Applications missing required information cannot be processed. Both pages 2 and 3 must each be personally signed (no electronic signatures) and dated to complete the application.

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**.

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

1. Prescribed medicine

Aimovig® (erenumab-aooe) **Otezla**® (apremilast)

2. 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** Best time to call **Morning** **Afternoon**

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

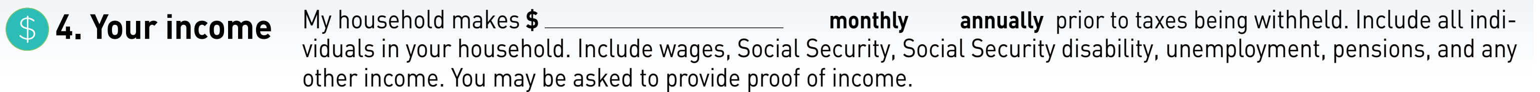
Email ______ By providing your phone number and email, you allow us to contact you to complete the application process.

3. Where you live

Are you a: **U.S. citizen** **Resident alien** **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**

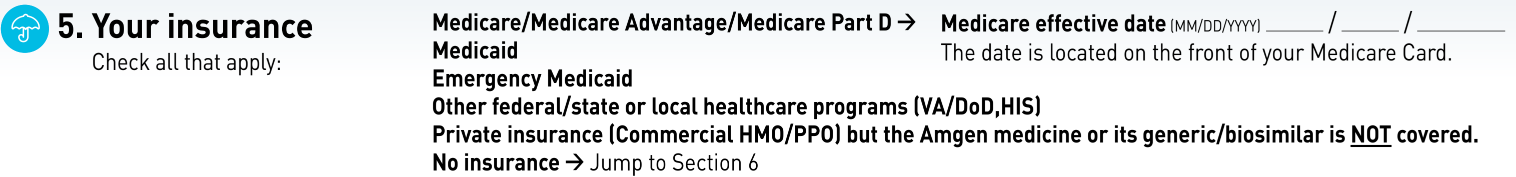


4. Your income

My household makes **$** ______ **monthly** **annually** 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 $29,250 if you are married and living with your spouse? Or worth more than $14,960 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 insurance

Check all that apply:

- **Medicare/Medicare Advantage/Medicare Part D →** **Medicare effective date** (MM/DD/YYYY) ____ / ____ / ____ The date is located on the front of your Medicare Card.
- **Medicaid**
- **Emergency Medicaid**
- **Other federal/state or local healthcare programs (VA/DoD,HIS)**
- **Private insurance (Commercial HMO/PPO) but the Amgen medicine or its generic/biosimilar is NOT covered.**
- **No insurance →** Jump to Section 6

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**

Your primary insurance
Healthcare Coverage, Medicare, or Medicaid

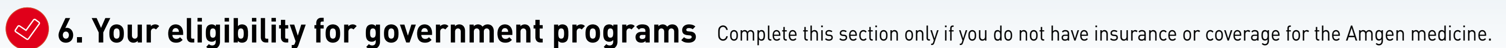
Insurer name ______ **Plan name** ______ **Plan phone #** ____ - ____ - ____
Subscriber name ______ **Relationship to patient** ______ **DOB** ____ / ____ / ____ (MM / DD / YYYY)
Member ID/policy # ______ **Group #** ______

Your pharmacy insurance
Prescription Coverage or Medicare Part D

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** ______



6. Your eligibility for government programs

Complete this section only if you do not have insurance or coverage for the Amgen medicine.

If you are not enrolled in Medicaid, please provide the following reasons: **Denied** (provide letter of denial) **Application pending** **Did not apply**

If your Medicaid application is pending, or if you did not apply, please answer the following:

Yes **No** Are you pregnant?
Yes **No** Are you legally blind or have you received a Social Security Disability status?
Yes **No** Do you receive Social Security Disability?
Yes **No** Are you a parent or caretaker relative of a child under the age of 18?

PATIENT CERTIFICATION

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

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) Electronic signatures not accepted ____________________

Dated MM/DD/YYYY ____________________

Please proceed to the next page.

PATIENT AUTHORIZATION

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

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 1-800-932-3060 and I may revoke it by mailing a revocation to PO Box 19148, 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 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) Electronic signatures not accepted | **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.

Last name ______________________ **First name** ______________________ **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	$64,400
Household of 2	$87,100
Household of 3	$109,800
Household of 4	$132,500
**Add $22,700 for each extra person*	

______________________ ______________________

Signature **Dated** MM/DD/YYYY

Completed forms can be submitted to:

Fax
1-833-959-1409

Mail
PO Box 19148
Lenexa, KS 66285

AMGEN® Safety Net Foundation

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 ______ / ______ / ______

Known drug allergies (Required entry. If no known drug allergies, check None.) **None** **Allergies**: ______________________

Concurrent medications (Required entry. If no known concurrent medications, check None.) **None** **Medications**: ______________________

Medication	Medication Dose	Frequency	Dispense Amount	Refills	Patient Diagnosis Code ICD-10 required if patient has insurance
Otezla® (apremilast)	4-week titration starter pack: 55 tablets	**As directed per package instructions** 10 mg daily on days 1-3, 20 mg daily on days 4-5, 30 mg once daily thereafter (for CrCl<30 ml/min) ______	28 days	0	**ICD-10** ______
	30 mg tablet	**Twice daily** Once daily (for CrCl<30 ml/min) ______	90 days ______	1 year x ______	**ICD-10** ______
Aimovig® (erenumab-aooe)	One 70 mg/ml Sureclick® One 140 mg/ml Sureclick®	Every two weeks Once monthly ______	90 days ______	1 year x ______	**ICD-10** ______

The needle shield within the orange cap of the Aimovig® autoinjector contains dry natural rubber which is made from latex. In order to ship the medication(s) our pharmacy is required to complete a Drug Utilization Review (DUR) that includes both review of other medications the patient is taking as well as cross referencing this new medication against any reported allergies.

Is the patient allergic to latex? **Yes** **No**

If the patient is allergic to latex, select one of the options below:

- Patient has a true latex allergy and should not receive Aimovig®
- Patient has tolerated latex in the past and is OK to receive Aimovig®
- Patient has mild topical allergy to latex but can receive Aimovig®

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 ______________________ **Contact name** ______________________

Phone ______ - ______ - ______ **Fax** ______ - ______ - ______

Prescribing physician name ______________________ ______________________ **Phone** ______ - ______ - ______
Last First

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.

Fax this prescription to 1-833-959-1409