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 _____

Patient date of birth 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 1-888-401-4931 and I may revoke my authorization by mailing a revocation to 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067. 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

Patient date of birth 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 1-888-401-4931 or by mailing a revocation to 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067, 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

Patient date of birth 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.