AMGEN ASSIST 360™
Support, Simplified

ENROLLMENT FORM

PLEASE COMPLETE THE SECTIONS THAT APPLY TO YOU

Insurance Verification Request

Insurance verifications and reimbursement support are available for all Amgen Assist 360™ products.

Complete section 1

Amgen Assist 360™ Patient Support Program Enrollment Request

If you are a patient prescribed KYPROLIS® (carfilzomib), IMLYGIC® (talimogene laherparepvec), or BLINCYTO® (blinatumomab), you can enroll in this additional complimentary patient support program that can help with co-pay and reimbursement assistance or connections to local independent third-party organizations for help with day-to-day challenges or transportation assistance, no matter where you live or what type of insurance you have.

Complete sections 1 2 *Healthcare provider (HCP) and patient authorization required for program enrollment.*

1 INSURANCE VERIFICATION

Patient Information

Patient First Name _____ MI _____ Patient Last Name _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Date of Birth ____ / ____ / ____ Gender ☐ F ☐ M

Alternate Contact/Caregiver Information:

First Name _____ Last Name _____ Phone Number _____

Relationship to Patient _____

Do you have the patient's consent for the program to contact the caregiver? ☐ Yes ☐ No

INSURANCE INFORMATION

Insured? ☐ Yes **Fill out Insurance Information** ☐ No **Skip to Amgen Medication and Coding Information**

Patient Primary Insurance Information		Patient Secondary Insurance Information	
Insurance Name		Insurance Name	
Policy #		Policy #	
Policy Holder Name		Policy Holder Name	
Date of Birth		Date of Birth	
Relation to Patient		Relation to Patient	
Insurance Phone #		Insurance Phone #	
Group #		Group #	

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MEDICATION AND CODING INFORMATION *(Check the medication(s) the patient has been prescribed.) Section 1, cont'd.*

Drug	J-code*	ICD/Dx	Secondary ICD code	Tertiary ICD code
☐ Aranesp® (darbepoetin alfa) injection	J0881			
☐ BLINCYTO® (blinatumomab) injection	J9039			
☐ IMLYGIC® (talimogene laherparepvec) suspension for injection	J3490/J3590/C9472			
☐ KYPROLIS® (carfilzomib) for injection	J9047			
☐ Neulasta® (pegfilgrastim) Onpro™ kit injection	J2505			
☐ Neulasta® (pegfilgrastim) prefilled syringe injection	J2505			
☐ NEUPOGEN® (filgrastim) injection	J1442			
☐ Nplate® (romiplostim) injection	J2796			
☐ Prolia® (denosumab) injection	J0897			
☐ Vectibix® (panitumumab) injection for IV infusion	J9303			
☐ XGEVA® (denosumab) injection	J0897			

Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for BLINCYTO® at blincyto.com.
Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for Aranesp® at aranesp.com.
Please see Full Prescribing Information, including **Boxed WARNINGS**, for Vectibix® at vectibix.com.

**For a full list of codes, refer to the Centers for Medicare & Medicaid Services 2016 Index*[1,2]

References: 1. Centers for Medicare & Medicaid Services. 2016 Alpha-Numeric HCPCS File. Available at: https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS-Items/2016-Alpha-Numeric-HCPCS-File.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending. Accessed June 30, 2016. **2.** Centers for Medicare & Medicaid Services. 2016 Alpha-Numeric HCPCS File. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals.html. Accessed August 3, 2016.

Previous therapies, if any:

Concurrent treatments, if any:

For Neulasta® Onpro™ Patients: Send a sharps disposal container? ☐ Yes ☐ No

Site of Care: ☐ Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Home Health ☐ Mail Order Pharmacy ☐ Specialty Pharmacy ☐ Retail Pharmacy ☐ Other

PRESCRIBER INFORMATION

Prescriber Name _____ State Where Licensed _____ State License # _____

Prescriber Type _____ NPI# _____

Physician Name *(if different from the prescriber)* _____ State Where Licensed _____ State License # _____

Payer Specific Provider Number _____

Facility Name _____ Facility Type ☐ Prescriber Office/Clinic ☐ Hospital Outpatient ☐ Hospital Inpatient

Facility Address* _____ City _____ State _____ Zip _____

**Product must be shipped to the signing prescriber's office or hospital address authorized by the prescriber and not to a third party.*

Primary Contact Name _____ Title/Role _____

Primary Phone # _____ Primary Fax # _____ Primary email _____

Do you have the patient's HIPAA consent on file authorizing the release of the patient's identification and insurance information to AMGEN and their agents and representatives for benefit verification and support services purposes? ☐ Yes ☐ No

2 HEALTHCARE PROVIDER (HCP) DECLARATION

By completing and faxing this form, you represent that your patient is aware of the disclosure of their personal health information to Amgen and its business partners for Amgen's patient support services, including reimbursement and verification services and the services provided by field reimbursement professionals in your office, as part of the patient's treatment with this product and that you have obtained appropriate patient authorizations as needed.

HCP Signature *(Required. May be original or stamped.)*

Date

Please fax completed forms to Amgen Assist 360™ at 888-407-9787.

2 PATIENT CONSENT AND RELEASE OF INFORMATION TO AMGEN ASSIST 360™

Signature or verbal consent is required for enrollment in the Amgen Assist 360™ Patient Support Program for IMLYGIC® (talimogene laherparepvec), KYPROLIS® (carfilzomib) and BLINCYTO® (blinatumomab). To provide verbal consent, please call 888-4ASSIST.

My signature below certifies that I agree to join the Amgen Assist 360™ patient support program and that I have read, understood, and agree to the Privacy Notice and Patient Authorization to release my personal health information as described in full detail on the following pages.

Date

Printed Name of Patient or Legal Representative

Signature of Patient or Legal Representative*

If signed by Legal Representative, explain authority to act on behalf of patient and relationship:

By signing above, I attest that I am legally able to sign such document: I am either (a) the patient and am at least 18 years of age, or (b) I am signing on the patient's behalf as his/her guardian or representative, I am legally able to do so, and I am properly acting in that capacity. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

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Amgen's Privacy Pledge to Patients

Amgen respects patients and customers and takes the protection of their privacy very seriously.
Amgen pledges the following:

- Amgen does not and will not sell or rent your information to marketing companies or mailing list brokers.
- Amgen is careful to only collect and/or use personal identifiable information for the purposes stated in this Authorization and as necessary to provide the services and/or programs the patient or customer chooses to enroll into.
- Amgen practices are consistent with federal and state privacy laws, including HIPAA.
- Amgen program enrollment is voluntary and always provides patients with an easy option to cancel participation.

Amgen's Privacy Notice and Patient Authorization

Uses and Disclose of Personal Information
I authorize Amgen and its contractors and business partners ("Amgen") to use and/or disclose my personal information, *including my personal health information*, only for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in Amgen's Amgen Assist 360™ program or any other Amgen-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse educator services, adherence programs and disease management support);
- To contact, with my permission, my doctor and the rest of my Health Care team and share with them my health information that may be useful for my care;
- **To provide me with informational and promotional materials relating to Amgen products and services, and/or my condition or treatment; and/or**
- To improve, develop, and evaluate products, services, materials and programs related to my condition or treatment

In order for Amgen to provide me with the services and/or programs described above, Amgen 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 select 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 authorize my Health Care Providers to disclose my *personal health information* to Amgen, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing my *personal health information* and/or for using my information to contact me with communications about Amgen products which have been prescribed to me (for example, adherence programs) and other patients support services.

Expiration, Right to Obtain a Copy and Right to Cancel
I understand that by signing this form, I authorize my Health Care Providers or others who might hold my health information to only release it to Amgen employees, as well as to its contractors and business partners, who are performing the services set forth in this Authorization. I also understand that I am authorizing my personal information, including my *personal health information*, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to release my personal health information for the earlier of (5) years or until my participation in the program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling Amgen at 888-427-7478 or by writing to PO Box 220354, Charlotte, NC 28222-0354. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my personal health information to Amgen on an ongoing basis, my cancellation with Amgen will be effective with respect to any such Health Care Providers as soon as they receive notice of my cancellation.

No Effect on Treatment
I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary. I understand that Amgen, as well as Health Care Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment or other care, to sign this Authorization. Federal Law (including HIPAA) requires a signed authorization in order for Amgen to collect this information from my Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

Information Received From Health Care Providers
I understand that once my personal health information has been disclosed to Amgen, federal privacy laws may no longer apply and protect it from further disclosure. Amgen agrees, however to protect my personal health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law. I understand that Amgen does not and will not sell or rent my information to marketing companies or mailing list brokers.

Authorization to Contact
I understand and consent to Amgen contacting me using the contact information provided in this form to enroll me in, operate, and administer Amgen patient support services and/or programs as described above other than promotional communications by telephone or SMS/text (which I can separately opt-in below). I understand that the operation and administration of certain of these services and/or programs may require that Amgen contact me by telephone or SMS/text.

☐ In addition to the above consent, I understand that by checking this box and signing [below], I consent to Amgen calling and texting me at the phone numbers I have provided with promotional communications relating to Amgen products and services and/or my condition or treatment. Amgen may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or SMS/text message (standard text messaging rates may apply). I understand that I am not required to provide this consent as a condition of purchasing any goods or services.

Name of participant	Signature of participant (or legal guardian)
Name of legal guardian (if needed)	Date