AMGEN ASSIST 360™
Support, Simplified

ENROLLMENT FORM

Please fill in the following page if you are a Blincyto® (blinatumomab), Imlygic® (talimogene laherparepvec), KYPROLIS® (carfilzomib), and/or Nplate® (romiplostim) patient enrolling in the Amgen Nurse Ambassador program.

PATIENT INFORMATION

First Name MI Last Name

Street Address City State Zip

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

Email Address

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

Product

☐ BLINCYTO® (blinatumomab) injection	☐ KYPROLIS® (carfilzomib) for injection
☐ IMLYGIC® (talimogene laherparepvec) suspension for injection	☐ Nplate® (romiplostim) injection

My signature below certifies that I agree to join the Amgen Assist 360 Nurse Ambassador* program and that I have read, understood, and agree to the Patient Authorization in order to release my personal health information as described in full detail on the accompanying pages.

Date

Printed Name of Patient

Signature of Patient

Name of Legal Guardian* (if needed)

Signature of Legal Guardian* (if needed)

**By signing above, I am indicating that I have read and understood Amgen's Patient Authorization (below in its full text), that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal guardian for Amgen and its contractors and business partners to use and share the personal information I provide for the purposes described within the Patient Authorization.*

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

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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 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 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 patient 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.