The Safety Net Foundation
Providing assistance to those in need.

PATIENT APPLICATION FORM

Instructions: This form should be used to assess The Safety Net Foundation eligibility for Amgen products. For assistance in completing this application, please call 1-888-SN-AMGEN (1-888-762-6436). Submission of this form is required to begin enrollment of a patient in The Safety Net Foundation sponsored by Amgen. Information supplied on this form will be strictly confidential.

Patient Information:

Patient's First Name:_____ Patient's Last Name:_____

Date of Birth:_____ Sex:_____
(MMDDYYYY)

Address: _____

City:_____ State:_____ Zip: _____

Primary Phone #:_____ Primary Phone # Type: ☐ Home ☐ Work ☐ Mobile

Secondary Phone #:_____ Secondary Phone # Type: ☐ Home ☐ Work ☐ Mobile

Fax #: _____

Does the patient live in the United States?: ☐ Yes ☐ No

Patient Email Address: _____

Patient's Preferred Method for Written Communications: ☐ Email ☐ Fax ☐ Mail

Annual Household Income: $ _____ Source of Income:_____

# of Persons in Household: _____

Insurance Information (*Please complete the information below to describe your health insurance status*)

☐ I am insured *(please fill out the insurance coverage section)*

☐ I am uninsured

Insurance Coverage

(Ex: Blue Shield of CA, AARP, VA/DOD, Indian Health Service, Discount Card Program)

Primary Patient Insurance Policy

Payor Name: _____

Plan Name: _____

Policy #:_____

Policy Phone #: _____

Subscriber Relation to Patient: _____

Subscriber First Name: _____

Subscriber Last Name: _____

Subscriber Employer: _____

Group #: _____

Secondary Patient Insurance Policy

Payor Name: _____

Plan Name: _____

Policy #:_____

Policy Phone #: _____

Subscriber Relation to Patient: _____

Subscriber First Name: _____

Subscriber Last Name: _____

Subscriber Employer: _____

Group #: _____

Medicare (A, B)

Enrollment Status: ☐ Yes ☐ Denied ☐ Pending ☐ N/A

Effective Date: _____

Telephone: ( )_____

Medicare Part D (Prescription Drug Plan)

Enrollment Status: ☐ Yes ☐ Denied ☐ Pending ☐ N/A

Effective Date: _____

Telephone: ( )_____

Medicaid

Enrollment Status: ☐ Yes ☐ Denied ☐ Pending ☐ Emergency ☐ N/A

Effective Date: _____

Telephone: ( )_____

Visit us at www.safetynetfoundation.com to access program information and forms, and submit online requests.

Patient's First Name: _____ Patient's Last Name: _____

Facility Mailing Information

(Facility information is not required for Sensipar® (cinacalcet), Nplate® (romiplostim), or Prolia™ (denosumab) patients going through the prospective shipment model. Go to Physician Information section for these products.)

Facility Name: _____

Contact Person Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Facility Product Shipping Information ☐ Check if shipping is same as mailing information

Confirm address where product should be shipped (if different from above.)

Facility Name: _____

Contact Person Name: _____

Address: _____
(PO BOX is not accepted)

City: _____ State: _____ Zip: _____

Phone #: _____

Physician Information:

Physician's First Name: _____ Physician's Last Name: _____

Physician's Facility Name: _____

Phone #: _____ Fax #: _____

Product Information

Products Utilized by Patient:

☐ Aranesp® (darbepoetin alfa)
☐ EPOGEN® (Epoetin alfa)
☐ Neulasta® (pegfilgrastim)
☐ NEUPOGEN® (Filgrastim)
☐ Nplate® (romiplostim)
☐ Prolia™ (denosumab)
☐ Sensipar® (cinacalcet)
☐ Vectibix® (panitumumab)

Patient's First Name: _____ Patient's Last Name: _____

What theraputic area is patient being treated for?

☐ Inflammation ☐ Nephrology ☐ Oncology ☐ Osteoporosis

For EPOGEN® (Epoetin Alfa) patients:

Is the patient currently on dialysis? ☐ Yes ☐ No

First date of dialysis: _____ Estimated EPOGEN® dose/week: _____

For Nplate® (romiplostim) patients:

Nplate® NEXUS Patient ID#: _____

Nplate® NEXUS Physician ID#: _____

For Prolia™ (denosumab) patients indicate Treatment Fulfillment Model[1]:

☐ Replacement ☐ Prospective

[1] Obtain this information from the facility contact or treating physician.

For Internal Use Only

Facility Customer Number: _____

PATIENT APPLICATION FORM

Patient's First Name:_____Patient's Last Name: _____

My doctor has prescribed Amgen products for me and I would like to receive the drug free of charge through The Safety Net Foundation (the "Foundation"). In order to participate, I hereby certify that the financial/insurance information listed above is accurate. I agree that this information can be provided to the Foundation, Amgen, and any agent of Amgen or the Foundation authorized to perform services on behalf of the Foundation.

I understand that, in order to determine my eligibility to participate in the Foundation, the Foundation needs information about my family income, and my health insurance. I agree to permit information about me to be provided to the Foundation, Amgen, and any agent of Amgen or the Foundation authorized to perform services on behalf of the Foundation, which will include a verification of my coverage with my insurance company, and to update my records to show that I continue to qualify for the Foundation. I further authorize the Foundation to provide Amgen with information concerning any assistance provided to me by the Foundation.

I also understand that my information may be provided to clinicians, social workers, and family members if reasonably necessary to complete the application or coordinate assistance. I understand that my assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that the Foundation reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

- I would like to receive Amgen products free of charge from The Safety Net Foundation. I do not have, nor am I eligible for, any private or public health insurance other than that listed above. I do not have, nor am I eligible for, any other form of public assistance with my medical expenses.
- I certify that I will not request reimbursement from any insurance carrier or government health benefit program for any Amgen products I receive from the Foundation.
- I certify that the above information is correct to the best of my knowledge. I understand that this information will not be used for any other purpose unless I give written consent, the government requires it, or The Safety Net Foundation removes my name and any other identifying information.
- I understand that The Safety Net Foundation may change or stop this program with respect to any patient, or in its entirety, at any time. I also understand that, although Amgen products may be given to me free of charge now, this does not mean I will be entitled to receive it free of charge indefinitely.
- I will not sell, trade, or distribute Amgen products given to me by The Safety Net Foundation.
- I understand that The Safety Net Foundation and such distributor as the Foundation may designate, may need to obtain my medical records from my physician and related information, including but not limited to my name, Social Security number, address, and date of birth, in order to assure continuity of care and in order for me to receive Amgen products. I authorize my physician to release to the Foundation all medical records and related information that may be necessary or helpful to the provision of Amgen products. I also authorize the Foundation, and its agents, to release medical information and related information to each other for purposes of my health care and in order for me to receive Amgen products. A photocopy of this authorization will be as valid as the original.
- I understand that The Safety Net Foundation, or its agents may need to work with my social worker or other dialysis center agent to case manage and coordinate care, including drug refills, on my behalf.
- The Safety Net Foundation reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. The Safety Net Foundation reserves the right to make an independent determination of financial need.

This consent expires the latter part of 1 year after the date of execution or 1 year after the last date I receive product under the program. I understand that this information identifying me will not be used for any purpose other than for the Foundation unless: (i) I give written consent, (ii) such disclosure is required by the government, or (iii) my name and any other identifying information are first removed.

_____ _____

Type or print name of legal representative (if applicable) Date

_____ _____

Signature of patient or legal representative Witness signature

Send completed forms to:

The Safety Net Foundation
PO BOX 13185
La Jolla, CA 92039-3185
Phone: 888/SN-AMGEN (888/762-6436) Fax: 866/549-7239

Visit us at www.safetynetfoundation.com to access program information and forms, and submit online requests.