The Safety Net Foundation
Providing assistance to those in need.

PRODUCT PRESCRIPTION FORM

Physician Instructions: Please complete form and fax or mail the completed application packet (Patient Application Form, Product Prescription Form and income documentation) to the address below.

To: The Safety Net Foundation
PO BOX 13185
La Jolla, CA 92039-3185
Phone: 1-888-SN-AMGEN (1-888-762-6436) Fax: 1-800-981-6690

From: Physician First Name:_____ Physician Last Name:_____
Physician Contact First Name (other than physician):_____ Physician Contact Last Name:_____
Facility/Practice Name:_____ Customer #:_____
Physician Email:_____ Physician Contact Email:_____
Mailing Address 1:_____
Mailing Address 2:_____
City:_____ State:_____ Zip Code:_____
Phone #:_____ FAX #:_____

State License Number (SLN)#:_____ **(Required)** DEA #:_____ **(Optional)**
NPI#:_____

Physician Preferred Method of Written Communication (primary) – check only one: ☐ Email ☐ Fax ☐ Mail
Physician Preferred Method of Written Communication (secondary) – check only one: ☐ Email ☐ Fax ☐ Mail

Product Shipping Information *(address where you would like product shipped)*

☐ Check here if product shipping address information is the same as physician mailing information

Shipping Address 1: (if different from mailing)_____
(PO BOX is not accepted)

Shipping Address 2: (if different from mailing)_____
(PO BOX is not accepted)

City:_____ State:_____ Zip Code: _____

Patient Information

Patient's First Name:_____ Patient's Last Name:_____
Date of Birth (MM/DD/YYYY):_____ Sex:_____ Email:_____
Primary Phone #_____ Primary Phone # Type: ☐ Home ☐ Work ☐ Mobile
Address 1:_____
Address 2:_____
City:_____ State:_____ Zip Code:_____

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

The Safety Net Foundation
Providing assistance to those in need.

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

Prescribing Information for Nplate® (romiplostim)

Nplate® NEXUS Patient ID#:(if applicable)_____ Nplate® Patient Diagnosis (required for Nplate®):_____
Nplate® NEXUS Physician ID#:_____
Nplate® NEXUS Facility ID#:_____

Medication	Dose	Frequency (weekly/monthly)	Check One	Quantity
Nplate®	250 mcg			
Nplate®	500 mcg			

Prescribing Information for Prolia™ (denosumab)

Medication	Dose	Frequency	Quantity
Prolia™	60 mg		

Prescribing Information for Sensipar® (cinacalcet)

Medication	Dose	Frequency	Check One	Quantity
Sensipar®	30 mg	_____daily	☐	12 month supply (2-month supply per shipment)
Sensipar®	60 mg		☐	
Sensipar®	90 mg		☐	

I have prescribed the product indicated above for the referenced patient. My patient gave consent for me to provide this information. I understand that no third party or patient should be billed or charged for the product provided by this program. I understand that no free product should be sold, traded, or distributed for sale.

X:_____ _____
Physician's Original Signature (stamps not accepted) Date

Completion of this form is part of the initial application process and does not guarantee enrollment in The Safety Net Foundation. The Foundation will review the completed application to determine the patient's eligibility.

For Internal Use Only: Case Number:_____ Patient ID:_____