PRODUCT REPLACEMENT REQUEST FORM

The Safety Net Foundation
Providing assistance to those in need.

Facility Name: _____ **Customer Number:** _____

Shipping Address 1: _____ **Facility Contact First Name:** _____

Shipping Address 2: _____ **Facility Contact Last Name:** _____

Shipping City: _____ **Title:** _____

Shipping State: _____ **Contact Phone Number:** _____

Shipping Zip Code: _____ **Contact Fax Number:** _____

The Safety Net Foundation
PO BOX 13185
La Jolla, CA 92039-3185

Patient Last Name	Patient First Name	Date of Birth (MM/DD/YYYY)	Product Name	Unit of Measure: Vial/Syringe/Units	Vial/Syringe Strength	Quantity Vials/Syringes/ Units Dispensed	Admin Start Date	Admin End Date	Total # of Administrations (Epoetin Alfa Only)

Certification Statement: By signing and submitting this application, I agree to the following:

*I certify that the Amgen product reported on this form, for which I am requesting free replacement, was furnished free of charge to the designated Safety Net Foundation patient. I represent that the information provided in this form is complete and accurate to the best of my knowledge and agree to notify The Safety Net Foundation of any changes I become aware of which could affect patient eligibility with The Safety Net Foundation. I further certify that I am authorized to act for the institution for which I am signing.

*I understand that The Safety Net Foundation is available for outpatient use only. I certify that no replacement will be requested for product administered in the hospital inpatient setting.

*I authorize this replacement order/prescription to be shipped to my office for in-facility use.

***I understand that either the physician OR the facility contact may sign this form. However, in the event that the signature below is not a physician's, The Safety Net Foundation will ship the closest wholesale quantity and credit any remaining balance to my facility's account.**

Signature allows for product shipment in single units (exact quantity requested)

Physician Signature: _____
(*Stamps not accepted*)

Physician First Name: _____ **Physician Last Name:** _____

Physician State License #: _____ **Date:** _____

Physician Email: _____

OR

Facility Contact Signature allows for wholesale product shipment. Physician product will be undershipped to the closest wholesale quantity.

Facility Contact Signature: _____
(*Stamps not accepted*)

Date: _____

Internal Processing Only

Date Received: _____

Send completed forms to:
The Safety Net Foundation, PO BOX 13185, La Jolla CA 92039-3185 Tel: 1-888-SN-AMGEN (1-888-762-6436)
Fax: 1-877-727-2867