

1-800-272-9376

SAFETY NET[®] Program

Instructions

The SAFETY NET[®] Program for Amgen product replaces product dispensed to eligible patients who qualify for the program. Patients must meet certain insurance and financial criteria. No cash payments are involved. A hospital, physician, home health care company, or community pharmacy may become a sponsor and must apply to the program on behalf of the patients.

If you prefer to preapprove a patient over the telephone, please call the SAFETY NET[®] Program for Amgen products at 800-272-9376. You will speak with a specialist who will determine if your patient is eligible for the program and who will assist you with completing Forms A and B. Please be prepared with the patient's name, Social Security number, annual family income, and insurance information. You will also need to first obtain the patient's consent to disclose confidential patient-identifiable information (name, Social Security number, address, ZIP code, policy number or employer), for purposes of seeking reimbursement assistance or enrollment into the SAFETY NET[®] Program. Eligible patients will be enrolled once the completed forms (Form A and Form B) are signed by the provider and patient and returned to the program by fax or mail.

If you prefer to complete your own applications, please follow the three steps listed below.

- Step 1:** A hospital, physician, home health care company, or community pharmacy may become a sponsor. To become a sponsor, the provider must sign a Sponsor Form (Form A), which confirms that the provider understands the program's terms. Form A needs to be submitted only once, regardless of the number of patients enrolled in the program. Additional documentation may be required.
- Step 2:** The sponsor submits a Patient Enrollment Form (Form B) for each patient, which is used to determine patient eligibility. **The patient's signature indicating consent to release confidential patient-identifiable information is required on this form.** The program specialist will contact the sponsor annually to confirm that the patient continues to meet eligibility criteria. Once a patient's 12-month enrollment period ends, a new Patient Enrollment Form (Form B) will be required for re-enrollment in the program. Additional documentation may be required.
- Step 3:** The sponsor submits the Amgen Product Dosage Tracking Form (Form C) at the end of each month or quarter for each enrolled patient. This form documents the amount of Amgen products to be replaced and must be signed by a physician or accompanied by a copy of the signed prescription. The provider will receive free replacement vials approximately 30 days after Form C is received by the program.

Amgen reserves the right to approve or deny any SAFETY NET[®] Program application or to modify or discontinue the program with respect to any patient or provider, or in its entirety, at any time. Amgen reserves the right to make an independent determination of medical indigence in all cases.

AMGEN[®]

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SAFETY NET[®] Program

Form A

Sponsor Form

Instructions: This form should be completed by a sponsor or SAFETY NET[®] Program Specialist (only once).

1. Sponsor Information

Sponsor Name _____

Contact Person _____

Title _____

Address _____

City _____ State _____ ZIP _____

Phone Number _____ Fax _____

If your facility is part of a chain or group-purchasing organization, please list the name:

Please indicate if the sponsor is a: _____ Hospital _____ Physician _____ Home Health Care*

_____ Dialysis Center _____ Home Dialysis Supplier _____ Community Pharmacy*

Physician/Facility License Number _____

EPOGEN[®] (Epoetin alfa) Preferred Unit Size _____ 2000 Units _____ 3000 Units

2. Product Shipping Information

Please provide contact person and shipment address for replacement product *if different* from above.

Sponsor Name _____

Shipping Contact Person _____

Title _____

Address _____

City _____ State _____ ZIP _____

Phone Number _____ Fax _____

*EPOGEN[®] is limited to physician, hospital, dialysis center, or home dialysis supplier.



3. Sponsor Certification and Consent

By submitting this application, I agree to the following:

- I will provide Amgen products for patients in a medically appropriate manner based on current standards of medical care.
- I understand that Amgen reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen products under this program to any patient or sponsor.
- I understand that an insurance verification may be required to determine a patient's eligibility for the SAFETY NET® Program.
- I understand that the product received through the SAFETY NET® Program is for medically needy patients living in the United States and its territories.
- I certify that no third party or patient has been or will be charged for Amgen products for which replacement is sought from Amgen under the SAFETY NET® Program. I further certify that all product received in connection with the SAFETY NET® Program will replace such product; be furnished free of charge for treatment of needy patients who meet SAFETY NET® Program criteria; and, that no part of any charges for Amgen products replaced under the SAFETY NET® Program will be claimed as bad debt on any of _____ (sponsor's name) cost reports.
- If I become aware of any changes in the patient's circumstances that affect SAFETY NET® Program eligibility, I agree to notify the SAFETY NET® Program immediately.
- I agree to release or make available to an authorized Amgen representative the medical and financial records for SAFETY NET® Program patients at any time for the sole purpose of verifying patients' eligibility for the SAFETY NET® Program, and I agree to obtain appropriate consent from each patient prior to releasing or making available to Amgen such records or information.
- I further certify that I am authorized to act for the institution for which I am signing.

Sponsor Signature _____ Date _____

Title _____

If you have any questions, please call the SAFETY NET® Program at 800-272-9376.

Send completed forms to:

SAFETY NET® Program
PO Box 13185
La Jolla, CA 92039-3185
Tel: 800-272-9376
Fax: 888-508-8090



Form B

Patient Enrollment Form

Instructions: For assistance in completing this application, please call 1-800-272-9376. Sponsors must contact the hotline or submit this form to begin enrollment of a patient in the SAFETY NET[®] Program for Amgen products. Information supplied on this form will be strictly confidential.

1. Sponsor Information

Sponsor Name _____
 Contact Person _____
 Sponsor Address _____
 Phone Number _____ Fax _____
 SAFETY NET[®] Program Sponsor Number _____

2. Patient Information

Patient Name _____
 Social Security Number _____ DOB _____
 Aranesp[™] (darbepoetin alfa) Neulasta[™] (pegfilgrastim) NEUPOGEN[®] (Filgrastim)
 Diagnosis _____ Estimated Dose/Day _____
 Is this being paid under a case rate? ____ Yes ____ No
 EPOGEN[®] (Epoetin alfa) Is the patient currently on dialysis? ____ Yes ____ No
 First Date of Dialysis _____ Estimated EPOGEN[®] Dose/Week _____
 Physician Name _____
 Physician Address _____

3. Financial/Insurance Information

- Income: Patient's adjusted annual gross family income _____

- Insurance: Please check all insurers from which this patient qualifies for benefits:

<u>Insurer</u>			<u>Status</u>		<u>Date</u>
Medicare	____ Yes	____ No	____ Pending	____ Denied	Effective _____
Medicaid	____ Yes	____ No	____ Pending	____ Denied	Effective _____
Commercial	____ Yes	____ No	____ Pending	____ Denied	Effective _____
VA/DoD	____ Yes	____ No	____ Pending	____ Denied	Effective _____
Managed Care Plan	____ Yes	____ No	____ Pending	____ Denied	Effective _____
Other Health Ins.	____ Yes	____ No	____ Pending	____ Denied	Effective _____

Name of Health Insurer _____



4. Patient Consent Statement

My doctor has prescribed Amgen products for me, and I would like to receive the drug free of charge through the SAFETY NET® Program. In order to participate, I hereby certify that the financial/insurance information listed on page 1 is accurate.

I understand that, in order to determine my eligibility to participate in the SAFETY NET® Program, Amgen needs information about the type and date of my medical diagnosis and treatment, my family income, and my health insurance. I agree to permit information about me to be given to Amgen to support my initial application, which may include a verification of coverage with my insurance company, and to update my records to show that I continue to qualify for the SAFETY NET® Program.

This consent expires the later of one year after the date of execution or one year after the last date I receive product under this program. I understand that this information identifying me will not be used for any purpose other than for the SAFETY NET® Program unless:

- I give written consent, or
- It is required by the government, or
- Amgen first removes my name and any other identifying information

Type or print name of patient

Date

Type or print name of legal representative (if applicable)

Witness signature

Signature of patient or legal representative

5. Sponsor Certification Statement

I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the SAFETY NET® Program of any changes that I become aware of, which could affect the patient's eligibility status.

Sponsor Signature _____ Date _____

Title _____ Phone Number _____

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La Jolla, CA 92039-3185
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Fax: 888-508-8090



Form C**Amgen Product Dosage Tracking Form**

Instructions: To receive replacement Amgen product within 30 days, sponsors should submit this form by mail at the end of each month or treatment cycle. **In order to be processed, the form must be signed by a physician.**

1. Sponsor Information

Sponsor Name _____ SAFETY NET[®] Sponsor Number _____
 Address _____
 Contact Name _____ Phone Number _____
 Fax Number _____

2. Certification Statement

I certify that the Amgen product reported on this form, for which I am requesting free replacement, was furnished free of charge to a SAFETY NET[®] Program patient and was purchased by me or my institution or provided free of charge by the SAFETY NET[®] Program. In addition, I represent that the information contained in this form is complete and accurate to the best of my knowledge and agree to notify the SAFETY NET[®] Program of any changes I become aware of which could affect the eligibility of this patient.

Physician Signature _____ **Date** _____

3. Amgen Product Utilization

Patient Name _____
 Social Security Number _____ DOB _____

Aranesp[™] (darbepoetin alfa)

Dates of administration: Start _____ End _____ Dose per administration _____

Total number of vials dispensed during period:

25 mcg/mL _____ 40 mcg/mL _____ 60 mcg/mL _____
 100 mcg/mL _____ 200 mcg/mL _____

EPOGEN[®] (Epoetin alfa)

Dates of administration: Start _____ End _____

Total EPOGEN[®] units dosed during period _____ Number of doses _____

Neulasta[™] (pegfilgrastim)

Dates of administration: Start _____ End _____ Dose per administration _____

Total number of prefilled syringes dispensed during period:

6 mg _____

NEUPOGEN[®] (Filgrastim)

Dates of administration: Start _____ End _____ Dose per administration _____

Total number of vials dispensed during period:

300 mcg/1.0 mL _____ 480 mcg/1.6 mL _____

Total number of prefilled syringes dispensed during period:

0.5 mL _____ 0.8 mL _____

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