SAFETY NET® Program

Form A

1-800-272-9376

Sponsor Form

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

1. Sponsor (Facility) Information

Sponsor (Facility) 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

Sponsor (Facility) Name _____

Contact Person _____

Title _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax _____

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

AMGEN

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_provider_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 _____

Send completed forms to:

SAFETY NET® Program

PO Box 13185

La Jolla, CA 92039-3185

Tel: 800-272-9376

Fax: 888-508-8090

SAFETY NET® Program

Form B 1-800-272-9376

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 (Facility) Information

Sponsor (Facility) 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 a bone marrow transplant patient? ___ Yes ___ No

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 _____

3. Physician Information

Physician Name _____

Physician Address _____

_____

4. Financial/Insurance Information

- Income: Patient's adjusted annual gross family income _____
- Insurance: Please check all insurers from which this patient qualifies for benefits:

Insurer			*Status*				*Date*
Medicare	___ Yes	___ No	___ Pending	___ Denied	Effective	_____	
Medicaid	___ Yes	___ No	___ Pending	___ Denied	Effective	_____	
VA/DoD	___ Yes	___ No	___ Pending	___ Denied	Effective	_____	
Commercial	___ Yes	___ No	___ Pending	___ Denied	Effective	_____	
Name of Commercial Health Insurer	_____						
Other Health Ins.	___ Yes	___ No	___ Pending	___ Denied	Effective	_____	
Name of Other Health Insurer	_____						

AMGEN

5. 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

6. 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 _____

Send completed forms to: SAFETY NET® Program

PO Box 13185

La Jolla, CA 92039-3185

Tel: 800-272-9376

Fax: 888-508-8090

SAFETY NET® Program

Form C **1-800-272-9376**

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 Sponsor contact.**

1. Sponsor (Facility) Information

Sponsor (Facility) 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.

I further certify that I am authorized to act for the institution for which I am signing.

Sponsor Signature _____ Date _____

Title _____

3. Amgen Product Utilization

Patient Name _____

Social Security Number _____ Date of Birth _____

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 _____

150 mcg/0.75mL _____ 200 mcg/mL _____ 300 mcg/mL _____ 500 mcg/mL _____

Total number of prefilled syringes dispensed during period:

25 mcg/0.42mL _____ 40 mcg/0.4mL _____ 60 mcg/0.3mL _____ 100 mcg/0.5mL _____

150 mcg/0.3mL _____ 200 mcg/0.4mL _____ 300 mcg/0.6mL _____ 500mcg/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: 300 mcg/0.5 mL _____ 480 mcg/0.8 mL _____

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