# AMGEN® Safety Net Foundation

Amgen Safety Net Foundation is a nonprofit patient assistance program that helps qualifying patients access Amgen medicines at no cost.

PATIENT APPLICATION

**Aimovig™** (erenumab-aooe)

## Are you eligible?

Apply for support if you meet the following requirements:

- **You have lived in the United States, American Samoa, Guam, Puerto Rico, or the U.S. Virgin Islands for six months or longer.**
- **You have a household income at or below:**
  $62,450 ..... for a household of 1 person
  $84,550 ..... for a household of 2 people
  $106,650..... for a household of 3 people
  $128,750..... for a household of 4 people
  *More than 4 in your household? Add $22,100 for each extra person*
- **You are uninsured or your insurance plan excludes the Amgen medicine.**
- **Certain Medicare Part D patients with coverage for the Amgen medicine who cannot afford their out of pocket costs may be eligible.**
  It is required that you are able to demonstrate:
  - Your inability to afford the medicine
  - Your ineligibility for Medicaid or Medicare's low-income subsidy (Extra Help)
  - You have satisfied all payer guidelines and Prior Authorization (PA) requirements prior to applying for assistance
  - You do not have any other financial support options

## How to apply

**STEP 1** Fill out and sign the **PATIENT APPLICATION** (pages 1-3). All fields need to be filled in for your application to be processed. Applications not completed in full will result in significant delays.

**STEP 2** Have your prescribing physician fill out the **PRESCRIPTION** (page 4).

**STEP 3** Have your prescribing physician fax the completed application and prescription to: **1-866-549-7239**

**What happens after I apply?**
You and your physician will be notified once a decision is made. If you are approved, you will be contacted by a Patient Assistance Counselor to obtain your consent and schedule a shipment of your medication.

## PATIENT INFORMATION

### 1. Your information

**Last name** _____ **First name** _____ **Middle initial** _____

**Date of birth** ____ / ____ / ____ (MM / DD / YYYY) **Social Security Number** ___ - ___ - ___ If you do not have a Social Security Number you may skip this question.

**Address** _____ **City** _____

**State** _____ **County** _____ **Zip Code** _____ ◯ **Male** ◯ **Female**

**Main telephone** ___ - ___ - ___ ◯ **Home** ◯ **Mobile** ◯ **Work**

**Secondary telephone** ___ - ___ - ___ ◯ **Home** ◯ **Mobile** ◯ **Work**

Please include a working phone number.
We may need to call you to complete the application process.

**Email** _____

### 2. Where you live

◯ **Yes** ◯ **No** Have you lived in the United States, American Samoa, Guam, Puerto Rico, or the U.S. Virgin Islands for six months or longer?

◯ **Yes** ◯ **No** Have you lived in your current state for six months or longer?

◯ **Yes** ◯ **No** Are you a U.S. citizen? You do not need to be a U.S. citizen to apply.

◯ **Yes** ◯ **No** Are you a resident alien who has lived in the U.S. for five years or longer?

**Name** _____ **Date of birth** ____ / ____ / ____ (MM / DD / YYYY)

## 3. Your income

My household makes $ _____ . _____

Every: ◯ **week** ◯ **other week** ◯ **month** ◯ **year**

Your gross income includes all individuals in your household. This includes wages, Social Security, Social Security disability, unemployment, any pensions, and any other income. You may be asked to provide proof of income.

How many people live in your household? (include yourself)

◯ **1** ◯ **2** ◯ **3** ◯ **4** ◯ **More than 4 → Print #** _____

Your household size includes all individuals you reported on your U.S. Tax Return. If you did not file a tax return please include all individuals that live with you. You, your spouse, your children, your parents, and any other family.

◯ **Yes** ◯ **No** Are your combined savings, investments and real estate worth more than $11,340 if you are married and living with your spouse; or worth more than $7,560 if you are not married or not living with your spouse? Do NOT count your home, vehicles, personal possessions, life insurance, burial plots, irrevocable burial contracts or back payments from Social Security or SSI.

## 4. Your eligibility for government programs

**Medicare**

◯ **Yes** ◯ **No** ◯ **Pending** Do you have Medicare? If you said yes, write your Medicare Effective Date here: ____ / ____ / ____ (MM / DD / YYYY)
It is on the front of your Medicare Card.

◯ **Yes** ◯ **No** ◯ **Pending** Do you have Medicare Part D?

If you have Medicare Part D and have applied for Medicare's Low Income Subsidy (Extra Help), which of the following decisions did you receive? ◯ **Full Support** ◯ **Partial Support** ◯ **Denied** ◯ **Did Not Apply**
You must include your letter from social security if you applied.

**Medicaid**

◯ **Yes** ◯ **No** Do you have Medicaid?

◯ **Yes** ◯ **No** If yes, is it Emergency Medicaid?
You MUST provide your Medicaid insurance information even if you only have Emergency Medicaid.

◯ **Yes** ◯ **No** Have you been denied Medicaid?
If you said yes, you MUST include your Medicaid denial letter. The letter must dated within the last 365 days.

◯ **Yes** ◯ **No** Are you pregnant?

◯ **Yes** ◯ **No** Are you legally blind or have you received a Social Security Disability status?

◯ **Yes** ◯ **No** Do you receive Social Security Disability?

◯ **Yes** ◯ **No** Are you a parent or caretaker relative of a child under the age of 18?

**Other**

◯ **Yes** ◯ **No** Are you eligible for or enrolled in any federal, state, or local government programs?
Including Veterans Affairs, Dept. of Defense, or Indian Health Services

## 5. Your insurance

Select the statement that applies to your insurance status:

◯ **I do not have health insurance.** You may skip Section 5.
◯ **I have health insurance (e.g. Commercial, Medicare, Medicaid) and the Amgen medication is NOT covered.** You must complete Section 5.
◯ **I have Medicare Part D and cannot afford my high out-of-pocket cost.** You must complete Section 5.

◯ **Yes** ◯ **No** If you have insurance, has your physician obtained approval from your health insurance plan ("Prior Authorization") to prescribe the medication to you?
If Yes, you will need to contact your health insurance plan to obtain the prior authorization end date and enter it here: ____ / ____ / ____ (MM / DD / YYYY)
If No, you must work with your physician and health insurance plan to meet all insurance plan requirements, guidelines, and prior authorization requirements OR submit a final appeal denial from your health insurance plan to apply.

**Your primary insurance**
Medicare, Medicaid, or Health Coverage

**Insurer name** _____ **Plan name** _____
**Plan phone #** ____ - ____ - ____
**Subscriber name** _____ **Subscriber relationship to patient** _____
**Member ID/policy #** _____ **Group #** _____

**Your secondary insurance**
Supplemental

**Insurer name** _____ **Plan name** _____
**Plan phone #** ____ - ____ - ____
**Subscriber name** _____ **Subscriber relationship to patient** _____
**Member ID/policy #** _____ **Group #** _____

**Your pharmacy insurance**
Medicare Part D or Prescription Coverage

**Insurer name** _____ **Plan name** _____
**Plan phone #** ____ - ____ - ____ **PCN #** _____ **BIN #** _____
**Subscriber name** _____ **Subscriber relationship to patient** _____
**Member ID/policy #** _____ **Group #** _____

**Your physician's information**

**First name** _____ **Last name** _____
**Address** _____
**State, Zipcode** _____ **Phone #** ____ - ____ - ____

# PATIENT CERTIFICATION AND AUTHORIZATION TO DISCLOSE INFORMATION

Amgen Safety Net Foundation "the Foundation" is a nonprofit patient assistance program that helps qualifying patients access Amgen medicines at no cost.

## Authorization to Disclose Information

I authorize the Foundation, Amgen, their agents, and third-party contractors or their service providers authorized to administer the Foundation to:

- Use the information that I provided on the Foundation application form to determine my eligibility for and assist with my continued participation in the Foundation.
- Obtain my consumer report from a consumer reporting agency to be used with the eligibility determination process.
- Contact me to seek feedback on the Foundation's services.

For these purposes, I also authorize my physician, healthcare professionals, health plan(s), care givers, and family members to disclose to the Foundation, Amgen, their agents, and third-party contractors or their service providers authorized to administer the Foundation information about my medical condition, treatment, and health insurance coverage.

I understand that:

- I may refuse to sign this form, but if I refuse to sign or revoke my authorization, I will not be able to receive assistance from the Foundation.
- My healthcare provider or insurers will not condition my medical treatment or insurance benefits on my agreement to sign this form.
- Once I provide the information as described above to the Foundation, Amgen, the agents, and third-party contractors or their service providers working on their behalf pursuant to this authorization, federal privacy laws may not prevent further disclosure of this information.
- I may receive a copy of this form at any time by contacting the Foundation at 1-888-762-6436 and I may revoke it by mailing a revocation to PO Box 18769, Louisville, KY 40261-7821.
- A revocation must be in writing and is not effective to the extent that action has already been taken based on this authorization.
- This authorization will expire one (1) year after the date it is signed below or one (1) year after the last date I receive medication from the Foundation, whichever is later.

## Patient Certification

I certify that:

- The information I provided on the Foundation application form is complete and accurate.
- I will not request reimbursement from any insurance carrier or government health benefit program for Amgen medications that I receive from the Foundation.
- I will notify the Foundation within thirty (30) days if my financial status or health insurance coverage changes.
- If I decide to enroll in a Medicare Part D plan, I will inform the Foundation at the number below prior to enrolling. If I receive notice that I have "auto-enrolled" in a Medicare Part D plan, I will immediately inform the Foundation.
- I will not sell, trade, or distribute Amgen medications given to me by the Foundation.

I understand that completing the Foundation application form is not a guarantee of eligibility for the Foundation. I also understand that the Foundation may change or discontinue the program at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year. I understand that if I am currently enrolled in a Medicare part D plan, I cannot utilize my Part D plan benefits for medications received through Amgen Safety Net Foundation for the duration of my enrollment in the Foundation.

Any medication I receive through Amgen Safety Net Foundation will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D. The Foundation reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen medications under this program to any patient or facility.

**Amgen Safety Net Foundation is not a state or federally funded program. The Foundation is sponsored solely by Amgen Inc.**

**Amgen Safety Net Foundation does not charge patients a fee for its assistance. Amgen Safety Net Foundation is not affiliated with third parties who charge a fee for assistance with enrollment or medication refills. If you are being charged a monthly fee for support from the Amgen Safety Net Foundation, the organization billing you is not the Amgen Safety Net Foundation and you are being charged for support that the Amgen Safety Net Foundation can provide to you directly at no cost.**

THIS CONSENT FORM REQUIRES A PATIENT'S PRINTED NAME, SIGNATURE AND DATE OF SIGNATURE IN ORDER FOR THE FOUNDATION TO BEGIN PROCESSING THE APPLICATION

**Printed Name of Patient or Personal Representative** _____

**Signature of Patient or Personal Representative** _____

**Dated** MM/DD/YYYY _____

**Description of Personal Representative's Authority to Sign for Patient** Attach documents which show authority _____

# AMGEN® Safety Net Foundation

PRESCRIPTION

Give this page to your prescribing physician to complete and fax along with your completed application. An original prescription is also accepted in place of this form.

## Patient

**Patient Name** _____ (Last) _____ (First)

**Sex:** ◯ **Male** ◯ **Female** **Date of Birth** MM/DD/YYYY ____ / ____ / ____

**Is the patient allergic to latex?** ◯ **Yes** ◯ **No**

## Prescription

| Medication | Medication Dose | Frequency | Dispense Amount | Refills | Patient Diagnosis Code ICD-10 required if patient has insurance |
|---|---|---|---|---|---|
| **Aimovig**™ (erenumab-aooe) | ☐ One 70mg/ml Sureclick®<br>☐ Two 70mg/ml or one 140mg/ml Sureclick® (based on availability)<br>☐ _____ | ☐ Once monthly<br>☐ _____ | ☐ 12-week supply<br>☐ _____ | ☐ 1 year or<br>☐ x _____ | **ICD-10** _____ |

New Enrollees: Aimovig™ is shipped monthly for the first 3 months, then every 3 months for the remaining number of refills.

## Facility/ Practice

**Facility/Practice Name** _____ **Contact Name** _____

**Phone** ____ - ____ - ____ **Fax** ____ - ____ - ____

## Prescribing Physician

**Prescribing Physician Name** _____ (Last) _____ (First)

**Phone** ____ - ____ - ____

**Street Address** _____ (Street (PO BOX not accepted)) _____ (City) _____ (State) _____ (ZIP)

**National Provider ID (NPI)** _____ **Tax ID** _____ Both IDs required

**Provider Transaction Access Number (PTAN)** Required if the patient has Medicare _____

I have prescribed the Amgen medicine indicated above for the referenced patient. My patient gave consent for me to provide this information. I understand that no third party or patient may be billed or charged for the Amgen medicine provided by this program. I understand that no medication received from Amgen Safety Net Foundation may be sold, traded, or distributed for sale.

**Prescribing Physician's Signature** Stamps not accepted _____ **State License Number** required _____ **Date Signed** MM/DD/YYYY _____

This form must be completed and submitted with the patient application but does not guarantee enrollment in or fulfillment of this prescription by the Amgen Safety Net Foundation. Amgen Safety Net Foundation must review the complete application including this prescription or an original script to determine the patient's eligibility.

**Fax this prescription to 1-866-549-7239**