The Safety Net Foundation

FOR PRESCRIPTION PRODUCTS

PATIENT ASSISTANCE PROGRAM (PAP) PATIENT ENROLLMENT FORM INSTRUCTIONS

Thank you for your interest in applying to The Safety Net Foundation, a nonprofit organization that helps qualifying patients access Amgen medicines at no cost. Patients with a prescription for an eligible Foundation product who meet the eligibility criteria for the foundation and are enrolled may have their prescription shipped directly to them by the foundation. Prolia® is shipped directly to the provider.

ELIGIBILITY GUIDELINES

- ✓ **Products Available with a Prescription:** Corlanor® (ivabradine) tablets, Enbrel® (etanercept), Prolia® (denosumab) injection for Bone Health, Repatha™ (evolocumab), and Sensipar® (cinacalcet) Tablets
- ✓ **Residence:** You must reside in the United States, Guam, Puerto Rico or the U.S. Virgin Islands
- ✓ **Insurance:** You have no insurance for or no access to other coverage or funding for the prescribed Amgen medication. For Medicare Part D patients meet additional criteria demonstrating inability to afford medications based on income.
- ✓ **Income:** Your annual household income meets foundation guidelines as follows:

Patient income guidelines for:	Number of people in household	Income must be at or below
CORLANOR® (ivabradine) tablets PROLIA® (denosumab) injection REPATHA™ (evolocumab) injection SENSIPAR® (cinacalcet) Tablets	1	$41,195
	2	$55,755
	3	$70,315
	4	$84,875
	Each additional person	Add $14,560

Patient income guidelines for:	Number of people in household	Income must be at or below
ENBREL® (etanercept)	1	$47,080
	2	$63,720
	3	$80,360
	4	$97,000
	Each additional person	Add $16,640

HOW TO APPLY CHECKLIST

FOR THE PATIENT:

☐ Complete the **PATIENT INFORMATION** section of the application
- If you have insurance, you must disclose this information. This includes enrollment in Medicare, Medicaid, or other government programs. Failure to do so may result in a denial.
- If insured, your diagnosis code is required to obtain coverage information. You can obtain this information from your Physician.

☐ Sign the **PATIENT CERTIFICATION AND AUTHORIZATION TO DISCLOSE INFORMATION**

☐ Fax the completed application to (866) 549-7239

WE CANNOT SCHEDULE A SHIPMENT UNTIL WE HAVE RECEIVED THE ORIGINAL SCRIPT OR THE PRODUCT PRESCRIPTION FORM* FROM YOUR PROVIDER.

FOR THE PROVIDER:

☐ Complete and sign the **PRODUCT PRESCRIPTION FORM* OR** give the patient the original script

☐ Fax the **PRODUCT PRESCRIPTION FORM* OR** original script to (866) 549-7239

ONCE A DECISION HAS BEEN MADE, THE PATIENT WILL BE NOTIFIED. MISSING INFORMATION AND/OR INCOMPLETE APPLICATIONS WILL RESULT IN PROCESSING DELAYS.

***THIS FORM IS ALSO AVAILABLE FOR DOWNLOAD AT WWW.SAFETYNETFOUNDATION.COM**

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PATIENT INFORMATION (ALL FIELDS ARE REQUIRED)

☐ Corlanor® (ivabradine) tablets ☐ Enbrel® (etanercept) ☐ Prolia® (denosumab) injection for **Bone Health**
☐ Repatha™ (evolocumab) ☐ Sensipar® (cinacalcet) Tablets

Patient Last Name: _____ Patient First Name: _____ M.I. _____

Date of Birth: _____-_____-_____ Social Security Number: _____-_____-_____ Sex: ☐ Male ☐ Female

Patient Mailing Address: _____ City:_____ State: _____ County: _____ Zip Code:_____

Patient Telephone: _____-_____-_____ _____-_____-_____
Primary ☐ Home ☐ Mobile ☐ Work Secondary ☐ Home ☐ Mobile ☐ Work

Patient phone number is required to obtain appropriate consent. Failure to provide accurate information will result in a denial for support.

Current Household Income: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly $ _____. _____ **Must include all income in the household including wages, Social Security, Social Security disability, unemployment, any pensions, and all other income.**

Total Number of People Within Household (including patient): **Circle One**
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 _____
Must include anyone on your Federal Tax Return*. If you do not file a Federal Tax Return include your spouse, children and parents who live with you. *You do not need to file a tax return to apply for The Safety Net Foundation.

☐ Yes ☐ No Are your combined savings, investments, and real estate worth more than $27,250 if you are married and living with your spouse, or worth more than $13,640 if you are not currently 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.

☐ Yes ☐ No Have you lived in the United States or its territories for six months or longer?

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

☐ Yes ☐ No Are you a US citizen or resident alien who has lived in the US for five years or longer?
You do not need to be a US Citizen to apply for The Safety Net Foundation.

☐ Yes ☐ No Are you pregnant?

☐ Yes ☐ No Are you legally blind or otherwise disabled?

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

☐ Yes ☐ No ☐ Emergency Only Are you enrolled in Medicaid? **If yes, the insurance section below must be completed.**
You must provide your Medicaid insurance information even if you only have Emergency Medicaid.

☐ Yes ☐ No Have you been denied Medicaid? **If yes, a Medicaid denial letter dated within the last 90 days must be submitted with this application. Failure to provide a Medicaid denial letter will result in a denial for support.**

☐ Yes ☐ No ☐ Pending Are you enrolled in Medicare? **If yes, the insurance section below must be completed.**

☐ Yes ☐ No ☐ Pending Are you enrolled in Medicare Part D? **If yes, the insurance section below must be completed.**

☐ Yes ☐ No Have you been denied Extra Help (i.e. LIS) from Social Security? **If yes, a denial letter must be submitted with this application.**

☐ Yes ☐ No Are you eligible for federal, state, or local government programs (VA/DOD/IHS)? **If yes, the insurance section below must be complete.**

☐ Yes ☐ No Do you have health insurance? **If yes, the insurance section below must be completed.**

Patient's Diagnosis Code(s), i.e. ICD-10: **Required if patient has insurance** _____ , _____

Primary Insurance (Medicare, Medicaid, or Health Coverage)	Insurer Name: _____ Plan Name: _____ Phone: _____ Subscriber Name: _____ Subscriber Relationship to Patient: _____ Member ID/Policy Number: _____ Group Number: _____
Secondary Insurance (Supplemental)	Insurer Name: _____ Plan Name: _____ Phone: _____ Subscriber Name: _____ Subscriber Relationship to Patient: _____ Member ID/Policy Number: _____ Group Number: _____
Pharmacy Insurance (Medicare Part D or Prescription Coverage)	Insurer Name: _____ Plan Name: _____ Phone: _____ Subscriber Name: _____ Subscriber Relationship to Patient: _____ Member ID/Policy Number: _____ Group Number: _____
Prescribing Physician	First Name:_____ Last Name: _____ Phone:_____- _____-_____ Fax : _____- _____-_____ NPI: _____ Tax ID:_____

PATIENT CERTIFICATION AND AUTHORIZATION TO DISCLOSE INFORMATION

The Safety Net Foundation "the Foundation" is a nonprofit patient assistance program supported by Amgen that provides qualifying patients with Amgen products 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.
- use my social security number to access my credit information and information derived from public and other sources to estimate my income in conjunction 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 product 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 products 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 products 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 products received through The Safety Net Foundation for the duration of my enrollment in the Foundation. Any medication I receive through The Safety Net Foundation will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D. The Safety Net Foundation will send a letter to my Medicare Part D plan notifying them of the assistance I am receiving.

Printed Name of Patient or Personal Representative	Signature of Patient or Personal Representative	Dated

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

Failure to provide authentic patient printed name and signature will result in a denial for support.

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FOR PRESCRIPTION PRODUCTS

PRODUCT PRESCRIPTION FORM (MUST COMPLETE ALL SECTIONS)

Patient

Patient Name: _____ (Last) _____ (First)

Sex: ☐ Male ☐ Female

Date of Birth: _____ - _____ - _____

Prescription

MEDICATION	MEDICATION DOSE	FREQUENCY	DISPENSE AMOUNT	REFILLS
Corlanor® (ivabradine) tablets	☐ 5 mg ☐ 7.5 mg ☐ _____	☐ _____	2 month supply	☐ 1 year or ☐ x _____
Prolia® (denosumab) injection for Bone Health Shipped directly to the provider	☐ 60 mg Pre-filled syringe ☐ _____	☐ _____	☐ _____	☐ 1 year or ☐ x _____
Repatha™ (evolocumab) injection	☐ 140 mg Pre-filled syringe ☐ 140 mg SureClick® ☐ _____	☐ Once every two weeks ☐ _____	☐ 12-wk supply ☐ _____	☐ 1 year or ☐ x _____
	New Enrollees/Step-down Dosing: Repatha™ is shipped monthly for the first 3 months, then every 3 months for the remaining number of refills.			
Sensipar® (cinacalcet) Tablets	☐ 30 mg ☐ 60 mg ☐ 90 mg ☐ _____	☐ _____	2 month supply	☐ 1 year or ☐ x _____
Enbrel® (etanercept)	☐ 50 mg SureClick® ☐ 50 mg Pre-filled syringe ☐ 25 mg Vial ☐ 25 mg Pre-filled syringe ☐ _____	☐ Once weekly ☐ Twice weekly ☐ Twice weekly for 3 months; then once weekly	☐ 12-wk supply ☐ ____wk supply	☐ 1 year or ☐ x _____
	New Enrollees/Step-down Dosing: ENBREL® is shipped monthly for the first 3 months, then every 3 months for the remaining number of refills.			

Facility/ Practice

Facility/Practice Name: _____

Facility Preferred Contact Name: (other than physician) _____

Prescribing Physician

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

Phone: _____ Fax : _____

Street Address: _____ (Street (PO BOX not accepted)) _____ (City) _____ (State) _____ (Zip)

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.

Physician's Signature (Stamps not accepted) | **State License Number** (required) | **Date Signed**

Completion of this form is independent of the application process and does not guarantee enrollment in The Safety Net Foundation. The Safety Net Foundation must review the complete application to determine the patient's eligibility.

- Provider may fax this completed product prescription form to **(866) 549-7239**
- Patients must mail this completed product prescription form to:

  The Safety Net Foundation PO Box 18769 Louisville, KY 40261-7821