

INSTITUTIONAL PATIENT ASSISTANCE PROGRAM (IPAP) ENROLLMENT FORM INSTRUCTIONS

- Provider: Complete the PATIENT INFORMATION section and have the patient sign/date the Patient Consent section
- Provider: Complete the PRODUCT INFORMATION and PHYSICIAN & FACILITY INFORMATION (page 2 of enrollment form)
- Provider: FAX the completed enrollment form to **(866) 549-7239**

NEXT STEP

Once we receive the enrollment form, you will be notified of the enrollment.

For any questions, please call (888) 762-6436, Monday through Friday, 9am to 9pm Eastern Time.

IPAP ENROLLMENT PATIENT INFORMATION

Patient Name:

Sex: Male Female

_____ / _____ / _____
 Last First M.I.

Date of Birth:

/ /

Social Security Number:

- -

Patient Address:

_____ Street

_____ City

_____ State

_____ Zip

Telephone:

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Home Mobile Work

Home Mobile Work

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.

I authorize the Foundation, Amgen, and their agents authorized to administer the Foundation as well as their respective service providers 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 other public 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 the sharing of information about my medical condition, treatment, and health insurance coverage between my physician, healthcare professionals, care givers, and family members and the Foundation, Amgen, and their agents authorized to administer the Foundation.

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 any Amgen products I receive from the Foundation.
- I will notify the Foundation within thirty (30) days if my financial status or health insurance coverage changes.
- 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.
- the Foundation may change or discontinue the program at any time without notice.
- 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 on the Foundation application form to the Foundation, Amgen and the agents 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 or revoke it at any time by contacting the Foundation at 1-888-SN-AMGEN (888-762-6436).
- 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.

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**Signature of patient
 or legal representative**

**Print Name of patient
 or legal representative**

Date Signed

The Safety Net Foundation reserves the right to modify or discontinue this program with respect to any patient, or in its entirety, at any time. The Safety Net Foundation also reserves the right to make an independent determination of financial need.

