AMGEN ASSIST®

INSURANCE VERIFICATION AND PRIOR AUTHORIZATION FORM

Please fill in the following 2 pages if you are a healthcare provider requesting insurance verification.

PATIENT INFORMATION

First Name | MI | Last Name

Street Address | City | State | ZIP

Phone Number | Date of Birth / / | Gender ☐ F ☐ M

Alternate Contact/Caregiver Information

First Name | Last Name | Phone Number

Relationship to Patient

Do you have the patient's consent for the program to contact the caregiver? ☐ Yes ☐ No

Patient Primary Insurance Information		**Patient Secondary Insurance Information**	
For LUMAKRAS™ (sotorasib), please provide Patient Pharmacy Insurance Information			
Insurance Name		Insurance Name	
Policy #		Policy #	
Policy Holder Name		Policy Holder Name	
Date of Birth		Date of Birth	
Relation to Patient		Relation to Patient	
Insurance Phone #		Insurance Phone #	
Group #		Group #	

PRESCRIBER INFORMATION

Prescriber Name | State Where Licensed | State License #

NPI # | Tax ID #

Physician Name
(if different from the prescriber) | State Where Licensed | State License #

Payer Specific Provider Number

Facility Name | Facility NPI # | Facility Type ☐ Prescriber Office/Clinic ☐ Hospital Outpatient ☐ Hospital Inpatient

Facility Address | City | State | ZIP

Primary Contact Name | Title/Role

Primary Phone # | Primary Fax # | Primary Email

By completing and faxing this form, you represent that your patient is aware of the disclosure of their personal health information to Amgen and its agents for Amgen's patient support services, including reimbursement and verification services and the services provided by field reimbursement professionals in your office, as part of the patient's treatment with this product and that you have obtained appropriate patient authorizations as needed.

DIGITAL DOWNLOAD

USA-OCF-82046 07/22

MEDICATION AND CODING INFORMATION *(Check the medication(s) the patient has been prescribed.)*

Product	HCPCS Codes	ICD/Dx	Secondary ICD code	Tertiary ICD code
☐ Aranesp® (darbepoetin alfa) injection	J0881			
☐ BLINCYTO® (blinatumomab) injection	J9039			
☐ Epogen® (epoetin alfa) injection	J0885			
☐ IMLYGIC® (talimogene laherparepvec) suspension for injection	J9325			
☐ KANJINTI® (trastuzumab-anns) for injection Treatment naive? ☐ Yes ☐ No	Q5117			
☐ KYPROLIS® (carfilzomib) for injection	J9047			
☐ LUMAKRAS™ (sotorasib) 120 mg tablets	N/A			
☐ MVASI® (bevacizumab-awwb) for injection Treatment naive? ☐ Yes ☐ No	Q5107			
☐ Neulasta® (pegfilgrastim) Onpro® injection	J2506			
☐ Neulasta® (pegfilgrastim) prefilled syringe injection	J2506			
☐ Parsabiv® (etelcalcetide) injection	J0606			
☐ NEUPOGEN® (filgrastim) injection	J1442			
☐ Nplate® (romiplostim) injection	J2796			
☐ Prolia® (denosumab) injection	J0897			
☐ RIABNI™ (rituximab-arrx)	Q5123			
☐ Sensipar™ (cinacalcet)	J0604			
☐ Vectibix® (panitumumab) injection for IV infusion	J9303			
☐ XGEVA® (denosumab) injection	J0897			

Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for Aranesp® at aranesp.com.
Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for BLINCYTO® at blincyto.com.
Please see Full Prescribing Information, including **Boxed WARNINGS**, for KANJINTI® at kanjinti.com.
Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for RIABNI™ at riabni.com.
Please see Full Prescribing Information, including **Boxed WARNINGS**, for Vectibix® at vectibix.com.

**For a full list of codes, refer to the Centers for Medicare & Medicaid Services Index*[1,2]

References: 1. Centers for Medicare & Medicaid Services. July 2022 Alpha-Numeric HCPCS File. Page last modified May 9, 2022. Accessed July 6, 2022. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update. **2.** Centers for Medicare & Medicaid Services. CMS Manual System. Transmittal 3685. Accessed July 8, 2022. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3685CP.pdf.

For Neulasta® Onpro® Patients: Send a sharps disposal container? ☐ Yes ☐ No

Site of Care: ☐ Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Home Health ☐ Mail Order Pharmacy ☐ Specialty Pharmacy ☐ Retail Pharmacy ☐ Other

Optional: Home Health Coverage (If desired, please fill in requested site name for verification.)_____

_____

AFFORDABILITY SCREENING

To see if the patient is eligible for additional affordability options, please complete the questions below

Residency: Patient has lived in the U.S. or its territories (American Samoa, Guam, Puerto Rico, or U.S. Virgin Islands):

☐ Greater than 6 months ☐ Less than 6 months

Patient household income: $ _____ ☐ Monthly ☐ Annually
(Gross income includes all individuals in the household. This includes wages, Social Security, Social Security disability, unemployment, pensions, and any other income. They may be asked to provide proof of income.)

How many people live in the patient's household (including the patient)?: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other _____

Household size includes all individuals reported on the patient's U.S. Tax Return. If the patient did not file a tax return please include all individuals that live with them.