AMGEN Support+

HCP REQUEST FORM

Please sign and fax the completed HCP Request Form to Amgen SupportPlus at **1-833-626-5384**.

Please NOTE: Amgen is committed to respecting the privacy of patients. Clinical notes and additional documents are **NOT required** for us to provide the services requested below. Review of clinical documentation sent to Amgen® SupportPlus could delay our response time back to your office. Please **DO NOT** provide anything beyond the information requested on this HCP Request Form.

Services Requested

- ☐ **I want a benefit verification.**
- ☐ **I want prior authorization requirements.**
- ☐ **I want to check the status of a prior authorization or appeal.**
- ☐ **I want specialty pharmacy triage.**

Preferred Specialty Pharmacy (SP) Name

SP Fax Number | SP Phone Number

Medication(s)

- ☐ ENBREL® (etanercept) Please see the ENBREL® full Prescribing Information, including Medication Guide.
- ☐ Otezla® (apremilast) Please see the Otezla® full Prescribing Information.
- ☐ AMJEVITA™ (adalimumab-atto) Please see the AMJEVITA™ full Prescribing Information, including Medication Guide.

Mandatory Patient, Insurance, and Prescriber Information

Section 1: Patient Information

First Name | Middle Initial | Last Name

__ __ / __ __ / __ __ __ __ Date of Birth (MM/DD/YYYY)

Sex at Birth: ☐ Male ☐ Female ☐ Prefer not to say

Address 1

Address 2 | City | State | Zip

Home Phone Number* | Mobile Phone Number* | Email Address

**By providing a phone number, you represent that your patient is aware of the disclosure and has given permission to be contacted by Amgen.*

Section 2: Insurance Information

☐ Patient has no insurance

Policy Holder: First Name | Middle Initial | Last Name

Medical Benefit Insurance: Provider | Policy Number | Group Number | Phone Number

Pharmacy Benefit Insurance: Provider | Member ID | PCN (If Applicable)

Group ID | BIN (If Applicable)

Section 3: Prescriber Information

First Name | Last Name | Facility Name

Address 1

Address 2 | City | State | Zip

Phone Number | Fax Number | NPI Number (required) | Office Contact Name

Prior Authorization and Appeals Information

Primary Indication

Secondary Indication

Affected Body Area(s)

Specialty Pharmacy Triage Prescription Information

Provide the patient's start date if you directly provided the in-office sample to your patient.

Date Sample Was Provided to Patient: __ __ / __ __ / __ __ __ __ (Month / Day / Year)

Formulation and Strength

Dosing

Quantity | Refills

Mandatory Signatures

Prescriber Signature (Dispense as Written) __ __ / __ __ / __ __ __ __

Supervising Physician Signature (Where Required) __ __ / __ __ / __ __ __ __ (Month / Day / Year)

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.

For any questions, please call 1-833-442-6436.

AMGEN