AMGEN® Support+

ENROLLMENT FORM

Please fill in the following pages to be contacted by an Amgen® Nurse Partner*.
***Required Field**

PATIENT INFORMATION

First Name* MI Last Name*

Street Address* City* State* ZIP*

Phone Number* Date of Birth* / / Gender ☐ F ☐ M ☐ Not Specified

Email Address

Privacy Statement — www.amgen.com/privacy

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

Prescriber Information

Prescriber Name

Facility Name Facility Phone Number

Facility Address City State ZIP

Product*

☐ Aranesp® (darbepoetin alfa)	☐ KANJINTI® (trastuzumab-anns)
☐ IMLYGIC® (talimogene laherparepvec)	☐ LUMAKRAS® (sotorasib)
☐ KYPROLIS® (carfilzomib)	☐ Neulasta® (pegfilgrastim)/Neulasta® (pegfilgrastim) Onpro® kit
☐ MVASI® (bevacizumab-awwb)	☐ Nplate® (romiplostim)
☐ NEUPOGEN® (filgrastim)	☐ RIABNI™ (rituximab-arrx)
☐ Vectibix® (panitumumab)	☐ XGEVA® (denosumab)
☐ BLINCYTO® (blinatumomab)	

You must read the Consent to Health Data Processing on page 3 and then select one of the responses. Select "I consent" to proceed with enrollment. If you select "I do not consent," you will not be able to continue enrolling in Amgen SupportPlus.
By signing below, I am indicating that I have read and understood the Authorization for Use and Disclosure of Protected Health Information (pages 2-3 in its full text), that I am legally authorized to consent, and that I am providing my consent as the patient or the patient's legal representative for Amgen and its contractors and business partners to use and share the personal information I provide for the purposes described within the Authorization for Use and Disclosure of Protected Health Information.

Date

Printed Name of Patient Signature of Patient

Name of Legal Representative (if needed) Signature of Legal Representative (if needed)

**Amgen Nurse Partners are only available to patients that are prescribed certain Amgen products. They are not part of your treatment team and do not provide medical advice, nursing, or case management services. Amgen Nurse Partners will not inject patients with Amgen medications. Patients should always consult their healthcare provider regarding medical decisions or treatment concerns.*

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.

AMGEN® Support+

For any questions, please call (866) 264-2778
Please fax completed forms to Amgen® SupportPlus at **866-218-4777**

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Authorization for Use and Disclosure of Protected Health Information

Please read the following carefully, then date and sign where indicated on page 1.
You must read the Consent to Health Data Processing on page 3 and then select one of the responses.
Select "I consent" to proceed with enrollment. If you select "I do not consent," you will not be able to continue enrolling in Amgen SupportPlus.

Uses and Disclosure of Protected Health Information

I authorize Amgen and its data processors (collectively, "Amgen") to collect, use, and disclose my protected health information for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in the Amgen SupportPlus program or any other Amgen-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse partner services, adherence program and disease management support);
- To contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care; and/or
- To improve, develop, and evaluate Amgen's products, services, materials and programs related to my condition or treatment.

In order for Amgen to provide me with the services and/or programs described above, Amgen needs to collect and use my personal information, including my protected health information. I understand that my protected health information may include any information, in electronic or physical form, in the possession of or derived from a health care provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor (each, a "Health Care Provider"). This may include select information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I authorize my Health Care Providers to disclose my protected health information to Amgen, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing my protected health information and/or for using my information to contact me with communications about Amgen products which have been prescribed to me (for example, medication reminder programs and other patient support services).

Expiration, Right to Obtain a Copy, and Right to Cancel

I understand that by signing this form, I authorize my Health Care Providers or others who might hold my health information to disclose it to Amgen. I also understand I am authorizing my personal information, including my protected health information, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to disclose my protected health information for the earlier of five (5) years or until my participation in the Amgen SupportPlus program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling Amgen at (866) 264-2778 or by writing to Amgen SupportPlus, 2202 N. Westshore Blvd Ste. 650, Tampa, FL 33607. If I cancel this Authorization, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my protected health information to Amgen in reliance on this Authorization on an on-going basis, my cancellation with Amgen will be effective with respect to any such Health Care Providers as soon as they receive notice of my cancellation.

No Effect on Treatment

I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary. I understand that Amgen, as well as Health Care Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment or other care, to sign this Authorization. Federal Law (including HIPAA) requires a signed authorization in order for Amgen to collect my protected health information from my Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

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Authorization for Use and Disclosure of Protected Health Information (cont'd)

Information Received from Health Care Providers
I understand that once my protected health information has been disclosed to Amgen, federal privacy laws may no longer apply and may no longer protect it from further disclosure, and that Amgen may disclose my protect health information to its data processors, contractors, and business partners for its business purposes. Amgen agrees, however, to protect my protected health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

U.S. State Law Consent to Process Health Data

Consent to Health Data Processing for Amgen SupportPlus

I consent to Amgen processing my Health Data for the following purposes:

- To enroll me and manage my participation in the Amgen SupportPlus program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, nurse partner support, disease management support), and to manage Amgen's products, services, and programs related to my condition or treatment.

Amgen uses the following when it administers the Amgen SupportPlus program:

- Health Data – my name (and the name of my caregiver if applicable), gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that my consent to processing is required for me to participate in the Amgen SupportPlus program. I also understand that Amgen will not sell my Health Data to third parties, but Amgen may disclose my Health Data to Amgen's data processors, contractors, and business partners for Amgen's business purposes related to the Amgen SupportPlus program. I understand that Amgen may use my Health Data to contact me by mail, email, telephone, or text for the above purposes. I also understand that if I do not consent to the use of my Health Data for the above purposes, I will not be able to participate in the Amgen SupportPlus program. Finally, I understand that I may withdraw my consent to processing my Health Data for the above purposes at any time using one of the methods listed in the Additional Disclosures section below and that if I withdraw my consent, I will no longer be able to participate in the Amgen SupportPlus program.

☐ I consent to the collection, processing, and disclosure of my Health Data for the above purposes

☐ I do not consent to the collection, processing, or disclosure of my Health Data for the above purposes

Additional Disclosures
I understand that participation in the Amgen SupportPlus program and, if I have consented, receipt of marketing communications are optional services at no cost to me. The consent(s) above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications. To obtain a copy of the consent(s) above or to withdraw my consent to collection, processing, and/or disclosure of my Health Data for any of the above purposes to which I have consented, I can contact Amgen by visiting www.amgen.com/DataSubjectRights or calling (866) 264-2778. For more information about Amgen's privacy practices, Amgen's Privacy Statement can be found at http://www.amgen.com/privacy.

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