AMGEN® Support+

ENROLLMENT FORM

Please fill in the following page if you are a patient enrolling in the Amgen Nurse Partner* program.
***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)	☐ BLINCYTO® (blinatumomab)
☐ IMLYGIC® (talimogene laherparepvec)	☐ KANJINTI® (trastuzumab-anns)
☐ KYPROLIS® (carfilzomib)	☐ LUMAKRAS® (sotorasib)
☐ MVASI® (bevacizumab-awwb)	☐ Neulasta® (pegfilgrastim)/Neulasta® (pegfilgrastim) Onpro® kit
☐ NEUPOGEN® (filgrastim)	☐ Nplate® (romiplostim)
☐ Prolia® (denosumab)	☐ RIABNI® (rituximab-arrx)
☐ Vectibix® (panitumumab)	☐ XGEVA® (denosumab)

By signing below, I am indicating that I have read and understood the Amgen Patient Authorization (next page 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 guardian for Amgen and its contractors and business partners to use and share the personal information I provide for the purposes described within the Patient Authorization.

Date

Printed Name of Patient Signature of Patient

Name of Legal Guardian (if needed) Signature of Legal Guardian (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 Patient Authorization

Uses and Disclose of Personal Information

I authorize Amgen and its contractors and business partners ("Amgen") to use and/or disclose my personal information, *including my personal health information*, only for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in Amgen's 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 educator services, adherence programs, and disease management support);
- To contact, with my permission, my doctor and the rest of my healthcare team and share with them my health information that may be useful for my care;
- **To provide me with informational and promotional materials relating to Amgen products and services, and/or my condition or treatment;** and/or
- To improve, develop, and evaluate 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 *personal health information*. I understand that my personal health information may include any information, in electronic or physical form, in the possession of or derived from a Healthcare Provider, healthcare plan, pharmacy, pharmaceutical company, laboratory and/or their contractor ("Healthcare Provider"). This may include select information from or about my medical history and general health, my healthcare plan benefits, payment limits or restrictions covered by my healthcare plan policy, and/or my adherence to my treatment.

I authorize my Healthcare Providers to disclose my *personal health information* to Amgen and between themselves as necessary, but only for the purposes stated above in this Authorization. I understand that certain Healthcare Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing my *personal 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 Healthcare Providers or others who might hold my health information to only release it to Amgen employees, as well as to its contractors and business partners, who are performing the services set forth in this Authorization. I also understand that I am authorizing my personal information, including my *personal 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 release my personal health information for the earlier of (5) years or until my participation in the 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 888-427-7478 or by writing to PO Box 220354, Charlotte, NC 28222-0354. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Healthcare Provider is disclosing my personal health information to Amgen on an ongoing basis, my cancellation with Amgen will be effective with respect to any such Healthcare 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 Healthcare 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 this information from my Healthcare Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Healthcare Providers.

Information Received from Healthcare Providers
I understand that once my personal health information has been disclosed to Amgen, federal privacy laws may no longer apply and protect it from further disclosure. Amgen agrees, however, to protect my personal health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

Authorization to Contact
I understand and consent to Amgen contacting me using the contact information provided in this form to enroll me in, operate, and administer Amgen patient support services and/or programs as described above other than promotional communications by telephone or SMS/text. I understand that the operation and administration of certain of these services and/or programs may require that Amgen contact me by telephone or SMS/text.