AMGEN® Support+

BRIDGE PROGRAM ENROLLMENT FORM INSTRUCTIONS

Please complete the form on the following page and fax to Amgen® SupportPlus at 1-888-407-9787 together with the following documents:

- ☐ Confirmation of Benefit Verification and supporting documentation (eg, Summary of Benefits and Coverage)
- ☐ Copy of Prior Authorization Form
- ☐ Copy of Insurance Card
- ☐ If applicable, copy of Claim or Medical Exception Denial and/or completed Appeal Forms

AMGEN

PRESCRIBER INFORMATION

Prescriber Name | State Where Licensed | NPI #

Physician Name | State Where Licensed | NPI #

Payer Specific Provider Number *(if different from the prescriber)* | Facility Name

Address | City | State | ZIP

Primary Contact Name | Title/Role

Primary Phone # | Primary Fax #

PRESCRIBER INFORMATION (Only complete if doses go from inpatient to outpatient site)

Prescriber Name | Facility Name

Address | City | State | ZIP

Primary Phone # | Primary Fax #

PATIENT INFORMATION

First Name | MI | Last Name

Address | City | State | ZIP

Phone # | Date of Birth / / | Gender ☐ Male ☐ Female

Alternate Contact/Caregiver Information (OPTIONAL)

First Name | Last Name | Phone #

Relationship to Patient

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

Patient Primary Insurance Information **Pharmacy Insurance Required*

☐ **Copy of insurance card provided. If not, fill in below.**

Insurance Name | Policy #

Policy Holder Name | Date of Birth / /

Relation to Patient

Insurance Phone # | BIN | PCN

Group #

Patient Secondary Insurance Information

☐ **Copy of insurance card provided. If not, fill in below.**

Insurance Name | Policy #

Policy Holder Name | Date of Birth / /

Relation to Patient

Insurance Phone # | BIN | PCN

Group #

PRESCRIPTION

Please see full Prescribing Information for important dosing and administration information.

Prescription	Strength/Formulation	Directions	Scheduling
IMDELLTRA™ (tarlatamab-dlle)	1-mg vial 10-mg vial	Please see IMDELLTRA™ Prescribing Information. IMDELLTRA™ should only be administered by a qualified healthcare professional in an appropriate healthcare setting.	Please see IMDELLTRA™ Prescribing Information. 1-hour intravenous infusion in an appropriate healthcare setting.

Previous and Current Treatment (attach list, if applicable)

Allergies, Current Health Conditions, and External Medications (attach list, if applicable)

PRESCRIBER AUTHORIZATION: By signing this Bridge Program Enrollment Form, I certify that I have prescribed IMDELLTRA™ (tarlatamab-dlle) based on my professional judgment of medical necessity consistent with the FDA approved indication and that I will supervise the patient's medical treatment. I authorize release of medical and/or other patient information relating to IMDELLTRA™ therapy to agents and service providers of Amgen to use and disclose as necessary for fulfillment of the prescription and to furnish any information on this form to the insurer of the above-named patient.

Prescriber Signature SIGN HERE | Date / /

Stamped signatures are not allowed.

DELIVERY PREFERENCES

Pending approval, please confirm dose and location of first supply shipment below.

☐ 1 mg ☐ 10 mg

Street Address | City | State | ZIP

Pending approval, please confirm dose and location of second supply shipment below.

☐ 1 mg ☐ 10 mg *If address is the same as first, only select dose.*

Street Address | City | State | ZIP

PLEASE NOTE THAT SIGNATURE WILL BE REQUIRED TO RECEIVE SUPPLY SHIPMENT. On approval, prescriber will receive a confirmation and the tracking number for your shipment in 1-2 business days.

PRESCRIBER ATTESTATION

I attest that the patient has had a prior authorization, appeal, or medical exception request denied or has not received a coverage decision within five (5) business days from the date the prior authorization was submitted for IMDELLTRA™ for use consistent with its FDA approved indication and that insurance coverage through the patient's insurance provider is being pursued; I will not bill, or assist with billing the patient, pharmacy or payer for IMDELLTRA™ provided through this program, and I have read and will comply with the Bridge Program Terms and Conditions.

By signing below, I understand that the Bridge Program provides IMDELLTRA™ only and does not provide support for any related costs, including costs for administration and monitoring.

Prescriber Print Name | Signature X SIGN HERE | Date / /

PATIENT AUTHORIZATION AND CONSENTS

IMDELLTRA™ BRIDGE PROGRAM TERMS & CONDITIONS - REQUIRED

☐ By checking this box, I agree that I have read, understand, and accept the Terms & Conditions of the IMDELLTRA™ Bridge Program on page 5.

CONSENT TO HEALTH DATA PROCESSING FOR IMDELLTRA™ BRIDGE PROGRAM - REQUIRED

You must read the Consent to Health Data Processing on pages 3 and 4 and then select one of the below responses. Select "I consent" to proceed with enrollment. If you select "I do not consent," you will not be able to continue enrolling in the Amgen IMDELLTRA™ Bridge Program.

☐ I consent to the collection, processing, and disclosure of my Health Data for purposes set forth on pages 3 and 4.

☐ I do not consent to the collection, processing, and disclosure of my Health Data for the purposes set forth on pages 3 and 4.

PATIENT AUTHORIZATION - REQUIRED

By signing below, I am indicating that I have read and understood the Authorization for Use and Disclosure of Protected Health Information on pages 3 and 4, 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.

Patient Print Name | Signature X SIGN HERE | Date / /

Signature by an adult will be required upon delivery.

Authorization for Use and Disclosure of Protected Health Information

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 IMDELLTRA™ (tarlatamab-dlle) Bridge 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, 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.

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 protected 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 IMDELLTRA™ (tarlatamab-dlle) Bridge program

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

- To enroll me and manage my participation in the IMDELLTRA™ Bridge 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 IMDELLTRA™ Bridge 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 IMDELLTRA™ Bridge program. I also understand that Amgen will not sell my Health Data to third parties, but may disclose my Health Data to Amgen's data processors, contractors, and business partners for Amgen's business purposes related to the IMDELLTRA™ Bridge 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 IMDELLTRA™ Bridge 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 IMDELLTRA™ Bridge program.

Additional Disclosures

I understand that participation in the IMDELLTRA™ Bridge 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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AMGEN® SUPPORTPLUS BRIDGE PROGRAM TERMS AND CONDITIONS

Program Details:

- **If the patient's health insurance plan has denied coverage of IMDELLTRA™ (tarlatamab-dlle) or has not provided a coverage decision within five (5) business days from the date the Prior Authorization (PA) was submitted to the insurance plan**, the Amgen® SupportPlus IMDELLTRA Bridge Program (the "Bridge Program") will provide IMDELLTRA™ at no cost to the patient, one (1) cycle at a time, up to a maximum of four (4) cycles, while the HCP continues to actively pursue insurance coverage. Support beyond four (4) cycles will be assessed based on medical necessity and handled on a case-by-case basis.
- This is a one-time offer and patients may participate only once whether or not they qualified or received less than four (4) cycles of IMDELLTRA under the Bridge Program.
- Patients who have not successfully obtained insurance coverage for IMDELLTRA™ after they received four (4) cycles under the Bridge Program are ineligible to re-enroll in the Program.
- See additional Terms and Conditions below including requirements necessary to maintain eligibility under the Bridge Program.

Terms and Conditions for the Bridge Program:

A patient who satisfies the Bridge Program eligibility requirements described herein and who is enrolled in the Bridge Program may receive up to four (4) cycles of IMDELLTRA™ at no cost, provided the requirements to receive subsequent remaining cycles, if any, described below are met. Patient eligibility ends after the patient receives four (4) cycles under the Bridge Program.

If at any time the patient begins receiving coverage under any commercial and/or federal, state, or government-funded healthcare program, the patient will no longer be eligible to participate in the Bridge Program and the healthcare provider or patient must call 833-44-AMGEN (1-833-442-6436) to stop participation.

Eligible Patients:

- Are 18 years or older
- Have health insurance (commercial or government)
- Have a prescription for IMDELLTRA™ for the FDA-approved indication and their healthcare provider has submitted a prior authorization to the patient's health insurance plan but the insurer has either not provided a coverage decision within five (5) business days from the date the PA was submitted or has denied coverage for the patient
- Acknowledge intent to pursue insurance coverage for IMDELLTRA™ with their healthcare provider and insurance plan as a requirement of participating in the Bridge Program
- Are no longer eligible for the Bridge Program once insurance approval is obtained
- Are no longer eligible for the Bridge Program once a final denial (meaning all methods for appealing the denial of insurance coverage for IMDELLTRA™ with their health insurance plan have been exhausted) is received by the patient/healthcare provider. The patient who has received a final denial is ineligible to receive subsequent remaining cycles, if any, of IMDELLTRA™ under the Bridge Program

Other Terms:

- Patients whose insurance covers IMDELLTRA™, but the patient cannot afford their out-of-pocket costs for the drug (including co-pays, coinsurance and/or deductibles) are ineligible to participate in the Bridge Program
- This offer is not valid if the patient is uninsured or is a cash paying patient
- Cash Discount Cards and other noninsurance plans are not valid as primary or secondary insurers under the Bridge Program
- Participating patients that fail to satisfy the Requirements to Receive Subsequent Remaining Cycles described below are not eligible to receive subsequent remaining cycles, if any, under the Bridge Program
- Once insurance approval is obtained, the patient is no longer eligible to participate in the Bridge Program
- Patients who have received a final denial (meaning all methods for appealing the denial of insurance coverage for IMDELLTRA™ with health insurance plan have been exhausted) are no longer eligible for the Bridge Program and are ineligible to receive subsequent remaining cycles, if any, of IMDELLTRA under the Bridge Program
- Patient eligibility ends following receipt of a final denial as described herein, or after the patient receives four (4) cycles under the Bridge Program, whichever occurs first.

Requirements to Receive Subsequent Remaining Cycles

- After the Bridge Program provides the enrolled patient's initial cycle of IMDELLTRA™, the participating patient is eligible for up to an additional three (3) cycles of IMDELLTRA™ under the Bridge Program. Each subsequent cycle is conditioned on the patient or their healthcare provider providing evidence to Amgen® SupportPlus of active steps taken to pursue IMDELLTRA™ insurance coverage from the patient's health insurance plan. Such "active steps" are determined by Amgen at Amgen's sole discretion and include, but may not be limited to, completion of all applicable insurer appeal processes for coverage denials. Each subsequent remaining cycle of IMDELLTRA under the Bridge Program will not be processed and shipped to the healthcare provider unless and until sufficient evidence of appeal activity is provided by the patient or their healthcare provider to Amgen® SupportPlus no later than 7 days prior to the patient's next scheduled cycle of IMDELLTRA™. Patients who have received a final denial (meaning all methods for appealing the denial of insurance coverage for IMDELLTRA™ with their health insurance plan have been exhausted) are no longer eligible for the Bridge Program and are ineligible to receive subsequent remaining cycles, if any,of IMDELLTRA™ under the Bridge Program.

No purchase necessary. **THIS IS NOT HEALTH INSURANCE.** Participation is not a guarantee of insurance coverage. This offer is not renewable. This offer is only valid in the United States, Puerto Rico, and the US territories. Other restrictions may apply. Amgen reserves the right to amend the program design and/or duration of the Bridge Program at Amgen's sole discretion. This offer is subject to change or discontinuation without notice.

If you have questions regarding these terms and conditions or Amgen® SupportPlus IMDELLTRA™ Bridge Program, please call 833-44-AMGEN (1-833-442-6436).