AMGEN Support+

PAVBLU™ (aflibercept-ayyh) PROGRAM ENROLLMENT FORM

Select program enrollment:

- ☐ **Benefits Verification** (Sections 1 and 3 to be completed)
- ☐ **Co-Pay Enrollment** (Sections 1 and 2 to be completed)
- ☐ **Both services** (All sections to be completed)

COMPLETE all required fields below, then submit via:

ONLINE:	**FAX PAGES 1-2:**
MyAmgenPortal.com	1-833-4PAVBLU (833-472-8258)

SECTIONS 1 AND 2 TO BE COMPLETED BY THE PATIENT OR LEGAL REPRESENTATIVE

1. Patient Information

An asterisk (*) indicates a required field

First Name* MI Last Name*

Street Address* City* State* Zip*

Phone Number* Date of Birth* / / Gender at birth ☐ F ☐ M

Email Address

Alternate Contact /Caregiver Information

First Name Last Name Phone Number

Relationship to Patient Email Address

☐ By checking this box, I agree that it is acceptable to leave a message with this alternate caregiver.

2. Amgen® SupportPlus Co-Pay Program Terms & Conditions (commercially insured patients only)

This section is only for Amgen® SupportPlus Co-Pay enrollment. To check eligibility for the Co-Pay Program, you must answer the questions below, agree to the Terms & Conditions and the Consent to Health Data Processing by checking the boxes below, and agree to the Patient Authorization by signing below.

REQUIRED (If enrolling in co-pay)

What type of insurance do you use to pay for your PAVBLU prescription and administration at the doctor's office? (Please select one option)

☐ Commercial insurance* (eg, self-purchased or through an employer) ☐ Government-provided (eg, Medicare Part D, Medicaid) ☐ I don't have insurance ☐ I don't know

***Copay card eligibility requires that the patient's commercial insurance pays for their Amgen medication**

Are you eligible for Medicare but receive prescription drug coverage from a former employer, union, or welfare plan?

☐ Yes ☐ No

☐ By checking this box, I agree that I have read, understand, and accept the Terms & Conditions of the Co-Pay Card Program on page 3.

CONSENT TO HEALTH DATA PROCESSING FOR AMGEN® SUPPORTPLUS CO-PAY CARD PROGRAM

You must read the Consent to Health Data Processing on page 5 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® SupportPlus Co-Pay Card Program.

☐ **I consent** to the collection, processing, and disclosure of my Health Data for the purposes set forth on page 5.

☐ **I do not consent** to the collection, processing, or disclosure of my Health Data for the purposes set forth on page 5.

PATIENT AUTHORIZATION – REQUIRED

I have read and agree to the Authorization for Use and Disclosure of Protected Health Information on pages 4 and 5 and understand that I must sign below to participate in the Amgen® SupportPlus Co-Pay Program.

Name of Patient: **Name of Legal Representative (if applicable):** **Today's Date*:** / /

Signature of Patient (or Legal Representative):

For any questions, please call Amgen® SupportPlus at (866) 264-2778.

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PAVBLU™ (aflibercept-ayyh) PROGRAM ENROLLMENT FORM

Patient First Name: Patient Last Name: Patient Date of Birth: / /

THIS PAGE TO BE COMPLETED BY A HEALTHCARE PROVIDER

Please NOTE: Clinical notes and additional documentation are **NOT required** for us to process a patient benefit verification. 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 benefit verification form.

3. Insurance Information

☐ Commercial/Private Insurance ☐ Medicare/Medicaid/TRICARE

	Primary Insurance ☐ Copy of card attached	Secondary Insurance ☐ Copy of card attached
Insurance Name		
Insurance Phone #		
Policy Holder Name		
Date of Birth		
Relation to Patient		
Policy #		
Group #		
Medicare Supplemental	X	☐ Yes If yes, Plan _____ ☐ No ☐ Not Known

Medicare Beneficiary ID# (Medicare/Medicare Advantage plans only):

Medication and Coding Information

Product	HCPCS Codes	ICD/Dx*	Secondary ICD Code	Tertiary ICD Code
PAVBLU™ (aflibercept-ayyh)	Q5147			

Treating Provider Information

An asterisk (*) indicates a required field

Physician Name* State Where Licensed* State License #*

NPI #* Tax ID #* PTAN #

Facility Information

Facility Name* Facility Type* ☐ Prescriber Office/Clinic ☐ Hospital Outpatient

Facility NPI #* Facility Tax ID*

Facility Address* City* State* Zip*

Primary Office Contact Name* Title/Role*

Primary Phone #* Primary Fax #* Primary Email*

By completing and submitting this form, you represent that your patient has requested and authorized the disclosure of their protected health information to Amgen and its agents for Amgen to provide the patient support services described in this paragraph. You represent that you have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Amgen and its agents will use the patient's name, date of birth, contact information, prescriptions, and other necessary health information listed in this form for reimbursement services related to this prescription, including to verify their insurance benefits, and to contact the patient directly for the administration of these patient support services; 2) Amgen will then disclose the patient's personal information to the insurer(s) listed on this form for the same purposes; 3) the patient can withdraw their consent by contacting Amgen at 1-866-264-2778 or visiting www.amgen.com/DataSubjectRights, but if the patient does not agree to, or withdraws consent for, these uses and disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Amgen to process the patient's personal information; and 4) the patient can view more details about Amgen's privacy practice at www.amgen.com/privacy.

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Amgen® SupportPlus Co-Pay Card Terms and Conditions

It is important that every patient read and understand the full Amgen SupportPlus Co-Pay Card Terms and Conditions. The following summary is not a substitute for reviewing the Terms and Conditions in their entirety.

As further described below, in general:

- The Amgen SupportPlus Co-Pay Card is open to patients with commercial insurance that covers PAVBLU™ (aflibercept-ayyh), regardless of financial need. The program is not valid for patients whose prescription and/or in-office administration costs for PAVBLU is paid for in whole or in part by Medicare, Medicaid, or any other federal or state healthcare program. The Amgen SupportPlus Co-Pay Card cannot be combined with any other savings, free trial, free goods or similar offer related to PAVBLU. It is not valid for cash paying patients or where prohibited by law. (See ELIGIBILITY section in the full Terms & Conditions.)
- The Amgen SupportPlus Co-Pay Card may help lower your PAVBLU out-of-pocket medication and in-office administration costs. Patients who are residents of Massachusetts or Rhode Island are not eligible for injection administration support. Out-of-pocket costs may include co-payment, co-insurance, and deductible out-of-pocket costs. The Amgen SupportPlus Co-Pay Card does not cover any other costs related to office visits. The Amgen SupportPlus Co-Pay Card provides support up to the Maximum Program Benefit or Patient Total Program Benefit. If a patient's commercial insurance plan imposes different or additional requirements on patients who receive Amgen SupportPlus Co-Pay Card benefits, Amgen has the right to modify or eliminate those benefits. Whether you are eligible to receive the Maximum Program Benefit or Patient Total Program Benefit is determined by the type of plan coverage you have. Please ask your Amgen SupportPlus Representative to help you understand eligibility for the Amgen SupportPlus Co-Pay Card, whether your particular insurance coverage is likely to result in your reaching the Maximum Program Benefit or your Patient Total Program Benefit amount by calling (866) 264-2778. (See PROGRAM BENEFITS section in the full Terms & Conditions.)
- Amgen SupportPlus patients may pay as little as $0 out-of-pocket for each dose of PAVBLU. Patients may also receive up to $1,000 per calendar year for out-of-pocket costs for in-office administration of PAVBLU. Patients who are residents of Massachusetts or Rhode Island are not eligible for injection administration support.

Amgen will pay the remaining eligible out-of-pocket costs on behalf of the patient until the Amgen payments have reached either the Maximum Program Benefit and/or the Patient Total Program Benefit. Patients are responsible for all amounts that exceed this limit. Please ask your Amgen SupportPlus Representative to help you understand eligibility for the Amgen SupportPlus Co-Pay Card by calling (866) 264-2778. (See PROGRAM DETAILS section in the full Terms & Conditions.)

Program coverage through the Amgen SupportPlus Co-Pay Card is contingent on (1) the submission of the required Explanation of Benefits (EOB) form within 180 days of the date of approval documented on the EOB for medical benefit claims or (2) the submission of the claim within 180 days of the date of service for pharmacy benefit claims. (See PROGRAM DETAILS section below.)

I. ELIGIBILITY

Eligibility Criteria: Subject to program limitations and terms and conditions, the Amgen SupportPlus Co-Pay Card is open to patients who have been prescribed PAVBLU and who have commercial or private insurance that covers PAVBLU, including state and federal plans commonly referred to as "healthcare exchange plans." This program helps eligible patients cover out-of-pocket medication costs related to PAVBLU, up to program limits. The Amgen SupportPlus Co-Pay Card does not cover any other costs related to office visits. There is no income requirement to participate in this program.

This offer is not valid for patients whose prescription for PAVBLU is paid for in whole or in part by Medicare, Medicaid, or any other federal or state healthcare program. The Amgen SupportPlus Co-Pay Card cannot be combined with any other savings, free trial, free goods or similar offer related to PAVBLU. It is not valid for cash-paying patients orwhere prohibited by law. A patient is considered cash-paying where the patient has no insurance coverage for PAVBLU or where the patient has commercial or private insurance but Amgen in its sole discretion determines the patient is effectively uninsured because such coverage does not provide a material level of financial assistance for the PAVBLU prescription. This offer is only valid in the United States, Puerto Rico, and the US territories.

II. PROGRAM BENEFITS

The Amgen SupportPlus Co-Pay Card may modify the benefit amount, unilaterally determined by Amgen in its sole discretion, to satisfy the out-of-pocket cost sharing requirement for any patient whose plan or plan agent (including, but not limited to, a Pharmacy Benefit Manager (PBM)) requires enrollment in the Amgen SupportPlus Co-Pay Card as a condition of the plan or PBM waiving some or all of an otherwise applicable patient out-of-pocket cost sharing amount. These programs are often referred to as co-pay maximizer programs. **If you believe your commercial insurance plan may have such limitations, please contact Amgen SupportPlus Support at (866) 264-2778.** Health plans and Pharmacy Benefit Managers are prohibited from enrolling patients or assisting in the enrollment of patients in the Amgen SupportPlus Co-Pay Card. **The patient, or his/her legal representative, must personally enroll in the Amgen SupportPlus Co-Pay Card in order to be eligible for program benefits.**

If at any time a patient begins receiving coverage for medications or in-office administration under any federal, state, or government healthcare program (including but not limited to Medicare, Medicaid, TRICARE, Department of Defense, or Veteran Affairs programs), the patient will no longer be able to use this card and you must contact **Amgen SupportPlus at (866) 264-2778** (Monday through Friday, from 9am to 8pm ET) to stop your participation in this program.

Patients may not seek reimbursement for the value received from the Amgen SupportPlus Co-Pay Card from any third-party payers, including a flexible spending account or healthcare savings account. Participating in this program means that you are ensuring you comply with any required disclosure regarding your participation in the Amgen SupportPlus Co-Pay Card of your insurance carrier or pharmacy benefit manager. Restrictions may apply. Offer subject to change or discontinuation without notice. **This is not health insurance.**

III. PROGRAM DETAILS

For all eligible patients the Amgen SupportPlus Co-Pay Card offers:

- A program benefit that covers the patient's eligible out-of-pocket medication and in-office administration costs for PAVBLU (co-pay, deductible, or co-insurance) on behalf of the patient, up to a Maximum Program Benefit determined by the program per calendar year. The Amgen SupportPlus Co-Pay Card does not cover any other costs related to office visits.
- Amgen SupportPlus patients may pay as little as $0 out-of-pocket for each dose of PAVBLU. Patients may also receive up to $1,000 per calendar year for out-of-pocket costs for in-office administration of PAVBLU. Patients who are residents of Massachusetts or Rhode Island are not eligible for injection administration support

Amgen will pay the remaining eligible out-of-pocket prescription costs on behalf of the patient until the Amgen payments have reached either the Maximum Program Benefit and/or the Patient Total Program Benefit. Patients are responsible for all amounts that exceed this limit.

Program coverage through the Amgen SupportPlus Co-Pay Card is contingent on (1) the submission of the required Explanation of Benefits (EOB) form within 180 days of the date of approval documented on the EOB for medical benefit claims or (2) the submission of the claim within 180 days of the date of service for pharmacy benefit claims.

Maximum Program Benefit, Patient Total Program Benefit, Benefits May Change, End or Vary Without Notice: The program provides up to a **Maximum Program Benefit** of support to reduce a patient's out-of-pocket medication costs that Amgen will provide per patient for each calendar year, which must be applied to the Amgen SupportPlus patient's out-of-pocket costs (co-pay, deductible, or co-insurance and annual out-of-pocket maximum). **Patient Total Program Benefit** amounts are unilaterally determined by Amgen in its sole discretion and will not exceed the Maximum Program Benefit. The Patient Total Program Benefit may be *less than* the Maximum Program Benefit, depending on the terms of a patient's plan, and *may vary among individual patients covered by different plans*, based on factors determined solely by Amgen, to ensure all programs funds are used for the benefit of the patient. Each patient is responsible for costs above the Patient Total Program Benefit amounts. Please ask your Amgen SupportPlus Representative to help you understand whether your particular insurance coverage is likely to result in your reaching the Maximum Program Benefit or your Patient Total Program Benefit amount by calling **(866) 264-2778**. Participating patients are solely responsible for updating Amgen with changes to their insurance including, but not limited to, initiation of insurance provided by the government, the addition of any coverage terms that do not apply Amgen SupportPlus Co-Pay Card benefits to reduce a patient's out-of-pocket costs, such as accumulator adjustment benefit design or a co-pay maximization program. Participating patients are responsible for providing Amgen with accurate information necessary to determine program eligibility. By accepting payments from Amgen made on behalf of participating patients, participating PBMs and Plans likewise are responsible for providing Amgen with accurate information regarding patient eligibility.

Patients may use the card every time they receive a dose of PAVBLU, up to the Maximum Program Benefit or Patient Total Program Benefit. Benefits reset each calendar year. Re-enrollment in the program is required at regular intervals. Patients may continue in the program as long as patient re-enrolls as required by Amgen and continues to meet all of the program's eligibility requirements during participation in the program. Patients can enroll/reenroll by calling **(866) 264-2778.**

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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 Amgen SupportPlus Co-Pay 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;
- 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 Co-Pay 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. 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.

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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 the Amgen SupportPlus Co-Pay Program

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

- To enroll me and manage my participation in the Amgen SupportPlus Co-Pay 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 Co-Pay 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 Co-Pay 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 Co-Pay 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 Co-Pay 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 Co-Pay Program.

Additional Disclosures

I understand that participation in the Amgen SupportPlus Co-Pay 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. 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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