AMGEN Support+

HCP REQUEST FORM

Please sign and fax the completed HCP Request Form to Amgen SupportPlus at **1-833-626-5384**. Please ensure your fax number is correct and legible to protect your patient's personal health information.

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 (select one brand)

☐ Otezla® (apremilast)
Please see the Otezla® full Prescribing Information.

☐ Enbrel® (etanercept)
Please see the ENBREL full Prescribing Information, including Medication Guide.

Has the patient started or is currently taking the prescribed medication? ☐ Yes ☐ No

Mandatory Patient, Insurance, and Prescriber Information

Section 1: Patient Information (Please ensure all fields are filled out as they are mandatory for processing.)

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 (Please ensure all fields are filled out as they are mandatory for processing.) ☐ 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 (Please ensure all fields are filled out as they are mandatory for processing.)

First Name | Last Name | Facility Name

Address 1

Address 2 | City | State | ZIP

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

Indication(s)

Primary Indication

Secondary Indication (if applicable)

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 has requested and authorized the disclosure of their personal 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 1-833-442-6436 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.

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

USA-916-84111

AMGEN