AMGEN Support+

INSURANCE VERIFICATION AND PRIOR AUTHORIZATION FORM

Please fill in the following 2 pages if you are a healthcare provider requesting insurance verification and fax completed forms to Amgen SupportPlus at **1-888-407-9787**.

Patient Information

First Name | MI | Last Name

Street Address | City | State | Zip

Phone Number | Date of Birth / / | Gender ☐ F ☐ M

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

Patient Primary Insurance Information	Patient Secondary Insurance Information
For LUMAKRAS® (sotorasib), please provide Patient Pharmacy Insurance Information	
Insurance Name	Insurance Name
Policy #	Policy #
Policy Holder Name	Policy Holder Name
Date of Birth	Date of Birth
Relation to Patient	Relation to Patient
Insurance Phone #	Insurance Phone #
Group #	Group #

Prescriber Information

Prescriber Name | State Where Licensed | State License #

NPI # | Tax ID #

Physician Name *(if different from the prescriber)* | State Where Licensed | State License #

Payer Specific Provider Number

Facility Name | Facility NPI # | Facility Type ☐ Prescriber Office/Clinic ☐ Hospital Outpatient ☐ Hospital Inpatient

Facility Address | City | State | Zip

Primary Contact Name | Title/Role

Primary Phone # | Primary Fax # | Primary Email

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.

By completing and faxing this form, you represent that your patient is aware of the disclosure of their personal health information to Amgen and its agents for Amgen's patient support services, including reimbursement and verification services and the services provided by field reimbursement professionals in your office, as part of the patient's treatment with this product and that you have obtained appropriate patient authorizations as needed.

For any questions, please call (866) 264-2778.

AMGEN®

Medication and Coding Information *(Check the medication(s) the patient has been prescribed.)*

Product	HCPCS Codes	ICD/Dx	Secondary ICD code	Tertiary ICD code
☐ Aranesp® (darbepoetin alfa) injection	J0881			
☐ BLINCYTO® (blinatumomab) injection	J9039			
☐ Epogen® (epoetin alfa) injection	J0885			
☐ IMLYGIC® (talimogene laherparepvec) suspension for injection	J9325			
☐ KANJINTI® (trastuzumab-anns) for injection	Q5117			
☐ KYPROLIS® (carfilzomib) for injection	J9047			
☐ LUMAKRAS® (sotorasib)	N/A			
☐ MVASI® (bevacizumab-awwb) for injection	Q5107			
☐ Neulasta® (pegfilgrastim) Onpro® injection	J2506			
☐ Neulasta® (pegfilgrastim) prefilled syringe injection	J2506			
☐ Parsabiv® (etelcalcetide) injection	J0606			
☐ NEUPOGEN® (filgrastim) injection	J1442			
☐ Nplate® (romiplostim) injection	J2796			
☐ Prolia® (denosumab) injection	J0897			
☐ RIABNI™ (rituximab-arrx)	Q5123			
☐ Sensipar™ (cinacalcet)	J0604			
☐ Vectibix® (panitumumab) injection for IV infusion	J9303			
☐ XGEVA® (denosumab) injection	J0897			

Please visit Amgen.com/products for Full Prescribing Information for the listed products.

**For a full list of codes, refer to the Centers for Medicare & Medicaid Services Index[1,2]*

References: 1. Centers for Medicare & Medicaid Services. January 2023 Alpha-Numeric HCPCS File. Page last modified December 21, 2022. Accessed February 6, 2023. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update. **2.** Centers for Medicare & Medicaid Services. CMS Manual System. Transmittal 3685. Accessed February 6, 2023. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3685CP.pdf.

For Neulasta® Onpro® Patients: Send a sharps disposal container? Yes ☐ No ☐

Site of Care: ☐ Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient ☐ Home Health ☐ Mail Order Pharmacy ☐ Specialty Pharmacy ☐ Retail Pharmacy ☐ Other

Optional: Home Health Coverage (If desired, please fill in requested site name for verification.)

First Option _____

Second Option _____

Affordability Screening

To see if the patient is eligible for additional affordability options, please complete the questions below

Residency: Patient has lived in the U.S. or its territories (American Samoa, Guam, Puerto Rico, or U.S. Virgin Islands):

☐ Greater than 6 months ☐ Less than 6 months

Patient household income: $ _____ ☐ Monthly ☐ Annually

(Gross income includes all individuals in the household. This includes wages, Social Security, Social Security disability, unemployment, pensions, and any other income. They may be asked to provide proof of income.)

How many people live in the patient's household (including the patient)?: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other _____

Household size includes all individuals reported on the patient's U.S. Tax Return. If the patient did not file a tax return please include all individuals that live with them.

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