



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**

*For LUMAKRAS® (sotorasib), please provide Patient Pharmacy Insurance Information*

Insurance Name \_\_\_\_\_

Policy # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Group # \_\_\_\_\_

**Patient Secondary Insurance Information**

Insurance Name \_\_\_\_\_

Policy # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Group # \_\_\_\_\_

**Prescriber Information**

Prescriber Name \_\_\_\_\_ State Where Licensed \_\_\_\_\_ State License # \_\_\_\_\_

NPI # \_\_\_\_\_ Tax ID # \_\_\_\_\_

Physician Name \_\_\_\_\_ State Where Licensed \_\_\_\_\_ State License # \_\_\_\_\_  
(if different from the prescriber)

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.

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

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

Please visit [Amgen.com/products](http://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<sup>1,2</sup>

**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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Policy Holder Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

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Insurance Phone # \_\_\_\_\_

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