

Insurance Verification Form

Fax with copies of insurance card(s), front and back, to Amgen® SupportPlus: 1-877-877-6542

prolia[®]
(denosumab)injection

Patient Information New Patient to Prolia® Existing Patient

*Patient Name: _____
 Attach patient demographic sheet **OR** Complete information below:
*Street Address: _____
*City: _____ *State: _____ *ZIP: _____
*Phone: _____
M F *Date of Birth: _____

Fulfillment Method (Select only ONE)

Medical Benefit (Physician Purchase)
 Pharmacy Benefit Out of Network Benefits
 Referral to treating site:
*Enter Site ID: _____ **OR** Complete information below.
*Site Name: _____
*Street Address: _____
*City: _____ *State: _____ *ZIP: _____
*Phone: _____ *Fax: _____
Office Contact: _____
*Site Type: MD Office Hospital Outpatient

Primary Insurance Information

Attach a copy of insurance card, front AND back **OR** provide:
*Insurance Name: _____
*Insurance Phone: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Relationship to Patient: _____
Group #: _____
*Policy #: _____
Medicare Beneficiary Identifier: _____

Secondary Insurance Information (If Applicable)

Attach a copy of insurance card, front AND back **OR** provide:
*Insurance Name: _____
*Is this a Medigap policy? Yes No Not Known
If yes, please indicate plan letter: _____
*Insurance Phone: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Relationship to Patient: _____
Group #: _____
*Policy #: _____

Pharmacy Insurance Information

Attach a copy of insurance card, front AND back **OR** provide:
*Pharmacy Insurance Patient ID #: _____
*Pharmacy Insurance Phone #: _____

*Asterisk fields are required for processing.

Physician Information

*Physician Name: _____
*NPI #: _____ Tax ID #: _____
Specialty: _____
*Enter Site ID: _____ **OR** Complete information below.
*Site NPI #: _____ Site Tax ID #: _____
*Site Name: _____
*Street Address: _____
*City: _____ *State: _____ *ZIP: _____
*Phone: _____ Fax: _____
Office Contact: _____
*Site Type: MD Office Hospital Outpatient

Patient Medical Information†

M81.0 (Age-related osteoporosis without current pathological fracture)
 M80.0 _____ (Age-related osteoporosis with current pathological fracture...) Please provide complete code
 Other (specify ICD Code) _____
Please provide secondary ICD Code, if applicable: _____
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.
†The sample diagnosis codes are informational and not intended to be directive or a guarantee of reimbursement and include potential codes that would include FDA approved indications for Prolia®. Other codes may be more appropriate given internal system guidelines, payer requirements, practice patterns, and the services rendered.

Prescription Information

Prolia® 60 mg pre-filled syringe, 60 mg SC every 6 months
Refill: x1
Prescriber Signature: (required for legal prescription triage)
X _____ Date: _____

Injection Date

Patient's Scheduled Injection Date: _____

OPTIONAL: 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.

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 (866) 264-2778 or visiting www.amgen.com/DataSubjectRights, but if the patient does not agree to, or withdraws consent for, these uses or disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Amgen to process the patient's personal information; 4) the patient can view more details about Amgen's privacy practice at www.amgen.com/privacy.

If you have any questions, please contact Amgen SupportPlus at (1-866-264-2778).

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Patient Information New Patient to EVENTITY[®] Existing Patient

*Patient Name: _____
 Attach patient demographic sheet **OR** Complete information below.
*Street Address: _____
*City: _____ *State: _____ *ZIP: _____
*Phone: _____
M F *Date of Birth: _____

Fulfillment Method (Select only ONE)

Medical Benefit (Physician Purchase) Out of Network Benefits
 Referral to treating site:
*Enter Site ID: _____ **OR** Complete information below.
*Site Name: _____
*Street Address: _____
*City: _____ *State: _____ *ZIP: _____
*Phone: _____ *Fax: _____
Office Contact: _____
*Site Type: MD Office Hospital Outpatient

Primary Insurance Information

Attach a copy of insurance card, front AND back **OR** provide:
*Insurance Name: _____
*Insurance Phone: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Relationship to Patient: _____
Group #: _____
*Policy #: _____
Medicare Beneficiary Identifier: _____

Secondary Insurance Information (If Applicable)

Attach a copy of insurance card, front AND back **OR** provide:
*Insurance Name: _____
*Is this a Medigap policy? Yes No Not Known
If yes, please indicate plan letter: _____
*Insurance Phone: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Relationship to Patient: _____
Group #: _____
*Policy #: _____

Prescription Information

EVENTITY[®] 210 mg SC every month for 12 doses
Prescriber Signature: (required for legal prescription triage)
_____ Date: _____

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Physician Information

*Physician Name: _____
*NPI #: _____ Tax ID #: _____
Specialty: _____
*Enter Site ID: _____ **OR** Complete information below.
*Site NPI #: _____ Site Tax ID #: _____
*Site Name: _____
*Street Address: _____
*City: _____ *State: _____ *ZIP: _____
*Phone: _____ Fax: _____
Office Contact: _____
*Site Type: MD Office Hospital Outpatient

Patient Medical Information[†]

M80.0 ____ (Age-related osteoporosis with current pathological fracture...) Please provide complete code
 M81.0 (Age-related osteoporosis without current pathological fracture)
 Other (specify ICD Code) _____
Please provide secondary ICD Code, if applicable: _____

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.

[†]The sample diagnosis codes are informational and not intended to be directive or a guarantee of reimbursement and include potential codes that would include the FDA approved indication for EVENTITY[®]. Other codes may be more appropriate given internal system guidelines, payer requirements, practice patterns, and the services rendered.

Continued Therapy

The anabolic effect of EVENTITY[®] wanes after 12 monthly doses of therapy. Consider whether continued therapy with an anti-resorptive is warranted after the end of the EVENTITY[®] treatment.

Would you like to be notified when your patient nears the end of their EVENTITY[®] treatment for a reminder regarding a follow-up anti-resorptive treatment such as Prolia[®] (denosumab)? Yes No

OPTIONAL: 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.