Insurance Verification Form

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

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)

✗ ______________________ 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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EVENITY® (romosozumab-aqqg) injection 105 mg/1.17 mL

Insurance Verification Form

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

Patient Information ☐ New Patient to EVENITY® ☐ Existing Patient

*Patient Name: ______________________

☐ Attach patient demographic sheet **OR** Complete information below.

*Street Address: ______________________

*City: ______________ *State: ________ *ZIP: ________

*Phone: ______________________

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

EVENITY® 210 mg SC every month for 12 doses

Prescriber Signature: (required for legal prescription triage)

______________________ Date: ______________

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.

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Continued Therapy

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

Would you like to be notified when your patient nears the end of their EVENITY® 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

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(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.)

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☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other ______________

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*Asterisk fields are required for processing.

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