



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 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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