The Safety Net Foundation
Providing assistance to those in need.

FORM A: SPONSOR ENROLLMENT FORM

Instructions: This form should be completed by a sponsoring facility or The Safety Net Foundation Specialist. This form only needs to be submitted once per sponsoring facility.

This form should be used to enroll as a sponsor in The Safety Net Foundation. Sponsorship is required prior to enrolling patients into the replacement program for Aranesp®, Neulasta®, NEUPOGEN®, EPOGEN®, and Vectibix®.

Sponsor (Facility) Mailing Information

Sponsor (Facility) Name: ______________________

Contact Person Name: ______________________

Title: ______________________

Facility Numbers: NPI: ____________ DEA: ____________ AHA: ____________ HIN: ____________

Mailing Address: ______________________

City: ____________ State: ____________ Zip: ____________

Phone Number: ____________ Fax Number: ____________

Email Address: ____________

Tell us how your facility would like to receive written communication, such as patient status and program updates. (Note that patient – specific updates cannot be sent via email at this time so the secondary method may need to be used for this purpose.)

Preferred Method of Written Contact (primary) – check only one: ☐ Email ☐ Postal Mail ☐ Fax

Preferred Method of Written Contact (secondary) – check only one: ☐ Email ☐ Postal Mail ☐ Fax

If your facility is part of a chain or group-purchasing organization, please list the name: ______________________

Please indicate if the sponsor is a:

	______ Physician Office	______ Hospital	______ Hospital Pharmacy
______ Community Pharmacy	______ Specialty Pharmacy	______ Dialysis Center: Hospital-Based	______ Dialysis Center: Free-Standing
______ Home Dialysis Supplier	______ Home Health Care	______ Transplant Center*	______ Infusion Center

***The Safety Net Foundation cannot provide assistance for inpatient hospital use.**
EPOGEN® Sponsors must be a physician office, hospital, dialysis center, home dialysis supplier, or transplant center.

Third Party Administrator Information

If your facility uses a third party administrator (TPA) to facilitate processing for patient assistance programs, please indicate:

This section must be filled out for all facilities that use a third party administrator (TPA). Note that the facility, not the TPA, will be the Safety Net Foundation sponsor.

Company Name: ______________________

Contact Person ______________________

Title ______________________

Address ______________________

City ______________________ State ____________ Zip ____________

Phone Number ______________________ Fax Number ______________________

Email Address ______________________

Preferred Method of Written Communication (Primary) – check one ☐ Email ☐ Postal Mail ☐ Fax

Preferred Method of Written Communication (Secondary) – check one ☐ Email ☐ Postal Mail ☐ Fax

The Safety Net Foundation ■ P.O. Box 13185 ■ La Jolla, CA 92039-3185 ■ Phone: 888/SN-AMGEN (888/762-6436) ■ Fax: 866/549-7239

Sponsor Name ______________________________________

Pharmacy Director information is required for sponsors that use third party administrators (TPAs) to ensure that they are aware of program updates and changes.

Pharmacy Director Information

If your facility has a Pharmacy Director, please list his/her name (*required for sponsors that use TPAs*):

Pharmacy Director Name: ______________________________________

Title ______________________________________

Address ______________________________________

City ____________________ State __________ Zip __________

Phone Number ____________________ Fax Number ____________________

Email Address ______________________________________

Preferred Method of Written Communication (Primary) – check one ☐ Email ☐ Postal Mail ☐ Fax

Preferred Method of Written Communication (Secondary) – check one ☐ Email ☐ Postal Mail ☐ Fax

Internal Use Only: The Safety Net Foundation Customer Number: ____________________

Tell us your facility's shipping address where replacement product should be shipped for your Safety Net patients, if different than your facility's mailing address.

Sponsor (Facility) Product Shipping Information

Confirm address where product should be shipped (if different than mailing address).

Sponsor (Facility) Name: ______________________________________

Shipment Contact Person Name: ______________________________________

Title ______________________________________

Address ______________________________________

(PO Box is not accepted)

City ____________________ State ____________________ Zip ____________________

Telephone ____________________ Fax ____________________

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SPONSOR CERTIFICATION AND CONSENT

Sponsor Name ____

By submitting this application, I agree to the following:

- I will provide Amgen products for patients in a medically appropriate manner based on a valid physician's order or prescription.
- I understand that The Safety Net Foundation reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen products under this program to any patient or sponsor.
- I understand that product is provided on a replacement basis. Participating providers are required to stock the product and apply for replacement product through The Safety Net Foundation.
- I understand that an insurance verification may be required to determine a patient's eligibility for The Safety Net Foundation.
- I understand that the product received through The Safety Net Foundation is for medically needy patients living in the United States and its territories.
- I certify that I will not charge or cause any other party to charge any third party or patient for Amgen products for which replacement is sought under The Safety Net Foundation. I further certify that all product received in connection with The Safety Net Foundation will replace such product; be furnished free of charge for treatment of needy patients who meet The Safety Net Foundation criteria; and, that no part of any charges for Amgen products replaced under The Safety Net Foundation will be claimed as bad debt.
- I understand that The Safety Net Foundation is available for outpatient use only. I certify that no replacement will be requested for product administered in the hospital inpatient setting.
- I represent that the information contained in all patient applications under my sponsorship, including Form B will be complete and accurate to the best of my knowledge. This representation does not require my independent investigation of the information. If I become aware of any changes in the patient's circumstances that affect Safety Net Foundation eligibility, I agree to notify The Safety Net Foundation immediately.
- I agree to release or make available to an authorized Safety Net Foundation representative the medical and financial records for Safety Net Foundation patients who have provided consent for such disclosure for the sole purpose of verifying patients' eligibility for The Safety Net Foundation. I agree that I will not provide patient information without obtaining appropriate consent from each patient prior to releasing or making available to The Safety Net` Foundation such records or information.
- I further certify that I am authorized to act for the institution for which I am signing.

Sponsors must agree to and sign off on program requirements.

Signature of Sponsor's Authorized Representative ____ Date: ______________

Title ____

Send completed forms to:

The Safety Net Foundation
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