

Insurance Verification Request Form for Neulasta®

Please complete this form and fax it to 1-888-508-8090 for processing.

Please confirm that this form is completed and faxed successfully to ensure timely completion of the research.

TREATING PHYSICIAN/FACILITY NAME _____

Address _____

Provider Number _____

City, State, Zip Code _____

Fax # (____) _____ - _____

Phone # (____) _____ - _____

Tax ID # _____

Contact Name _____

REQUESTOR PREFERENCES

Please check all settings of care you would like researched

Office

Retail Pharmacy

Mail Order

How would you prefer results relayed?

Phone

Fax

No preference

PATIENT INFORMATION

Patient Name _____

Date of Birth ____/____/____ (mm/dd/yy)

Phone # (____) _____ - _____

Social Security # _____ - _____ - _____

PATIENT MEDICAL AND TREATMENT HISTORY

Diagnosis (please include ICD-9 code):

Primary ____ Secondary ____

Patient weight in kilograms: _____kgs

Initial date of service: ____/____/____ (mm/dd/yy)

Patient's chemotherapy regimen:

Patient's absolute neutrophil count (ANC) upon Neulasta® initiation:

Is patient currently on NEUPOGEN® (Filgrastim)? ____ Yes ____ No

If, yes, date of last dose of NEUPOGEN® ____/____/____ (mm/dd/yy)

PRIMARY INSURANCE (INSURER NAME) _____

State _____

Phone # (____) _____ - _____

Fax # (____) _____ - _____

Policyholder's Name _____

Relation to Patient _____

Policyholder's Birth Date ____/____/____ (mm/dd/yy) _____

Social Security # _____ - _____ - _____

Policy # _____

Group/Plan # _____

Employer's Name _____

Policyholder's Phone # (____) _____ - _____

SECONDARY INSURANCE (INSURER NAME) _____

State _____

Phone # (____) _____ - _____

Fax # (____) _____ - _____

Policyholder's Name* _____

Relation to Patient* _____

Policyholder's Birth Date* ____/____/____ (mm/dd/yy) _____

Social Security #* _____ - _____ - _____

Policy # _____

Group/Plan # _____

Employer's Name* _____

Policyholder's Phone # (____) _____ - _____

*This verification of benefits is not a guarantee of payment by the payer, but is deemed as current coverage information as relayed by the payer to the Amgen Reimbursement Connection®.
This verification cannot take the place of written policy information from the payer.*

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I agree to permit my health care provider, _____ (“Provider”), to disclose to Amgen, the manufacturer and/or distributor of certain biotechnology products, and its contractor, Covance (together, “Company”), information about me and my medical condition as is reasonably necessary to:

- obtain information on insurance coverage and payment for _____ (drug name), and any other Amgen products that may be prescribed to me during my treatment (collectively, “Amgen Products”),
- and determine if I may be eligible to participate in an available patient assistance program.

In carrying out these activities, Company may share the information about me with my health insurers, if any. My health insurers may respond by disclosing information about me and my insurance coverage to Company. Company may share the insurers’ responses with my Provider.

Once my health information has been disclosed by my Provider and my health insurers to Company, federal privacy laws may no longer protect the information from further disclosure. However, Company agrees to protect my information by using and disclosing it only for the purposes described above or as required by law. My health information will not be used or disclosed by Company for any other purpose unless information that identifies me is first removed. These limitations continue even after this Authorization expires (ends) or I revoke (take back) this Authorization. I understand that:

- I do not have to sign this Authorization, but if I don’t, Company will be unable to verify my insurance coverage for Amgen Products or determine if I may be eligible to participate in an available patient assistance program.
- My Provider and my health insurers will not condition my medical treatment, payment for treatment, or insurance benefits on my agreement to sign this Authorization. However, if I do not sign this Authorization, I may have to pay for Amgen Products myself.
- I may revoke (take back) this Authorization at any time by calling: 1-800-272-9376. If I revoke this Authorization, however, Company may be unable to assist my Provider in obtaining payment for Amgen Products or determining if I may be eligible to participate in an available patient assistance program.
- Revoking this Authorization will prevent my Provider and my health insurers from making further disclosures of my health information to Company after the date my letter of revocation is received and processed by them. However, revoking this Authorization will not affect Company’s ability to use and disclose any information it has already received.
- I am entitled to a copy of this Authorization; this Authorization expires ten years from the date of my signature.

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Legal Representative

Legal Representative’s Relationship to Patient