Amgen Reimbursement Connection®
1-800-272-9376 (telephone)
1-888-508-8090 (fax)

Insurance Verification Request Form for Sensipar®

☐ **Pursue Prior Authorization if Needed**
*(Please fill out Prior Treatment History below)

PHYSICIAN/FACILITY INFORMATION

Contact/Requestor Name____________________ Phone (_______) - _______ - ____________
Facility Name____________________ Fax (________) - ________ - ____________
Treating Physician's Name____________________ State License #____________
Address____________________ Tax ID # ____________
PTAN #____________________ Physician Specialty____________
City, State, Zip____________________ Contact/Requestor Email Address____________
NPI #____________________

REQUESTOR PREFERENCES

Primary Contact for Relaying Results: ☐ Provider Contact/Requestor ☐ Physician ☐ Patient
How would you prefer results relayed? ☐ Phone ☐ Fax ☐ No preference
Please check all settings of care you would like researched:

☐ Retail Pharmacy (approx 24 hour turnaround) ☐ Mail Order Pharmacy (approx 48 hour turnaround) ☐ Specialty Pharmacy (approx 48 hour turnaround)

PATIENT GENERAL INFORMATION

Patient First and Last Name____________________ Patient DOB________ / ________ / ________ (mm/dd/yy)
Patient Phone (_________) - ___________ - ____________ Patient State & Zip Code____________
Patient Address____________________ Patient Email Address____________

PATIENT MEDICAL INFORMATION

Relevant Diagnosis (ICD-9 code)

☐ 585.6 ☐ 585.9 ☐ 588.81 ☐ Other (specify ICD-9 code) ____________

Dosage: ☐ 30mg ☐ 60mg ☐ 90mg ☐ Other (specify Dosage) ____________

PRIMARY INSURANCE (Please fax copy of front AND back of insurance card(s) OR provide the information below.)

Insurance Name____________________ Insurance State____________
Is this a Medicare Part D Plan? ☐ Yes ☐ No If yes, provide name of Medicare Part D Plan____________
Insurance Phone Number (________) - _________ - ____________ Insurance Fax Number (___________) - ________ - ____________
Payor's Assigned Physician #____________________ Policyholder's Name____________
BIN #____________________ Policy Number____________
Policyholder's Employer____________________ Plan Name ____________
Relationship to Patient____________________ Group/Plan Number____________
Policyholder's Phone (________) - _________ - ____________

SECONDARY INSURANCE *(Complete only if different from primary insurance information.)*

Insurance Name____________________ Insurance State____________
Is this a Medicare Part D Plan? ☐ Yes ☐ No If yes, provide name of Medicare Part D Plan____________
Insurance Phone Number (________) - _________ - ____________ Insurance Fax Number (__________) - ________ - ____________
Payor's Assigned Physician #____________________ Policyholder's Name____________
BIN #____________________ Policy Number____________
Policyholder's Employer____________________ Plan Name ____________
Relationship to Patient____________________ Group/Plan Number____________
Policyholder's Phone (________) - _________ - ____________

***PRIOR TREATMENT HISTORY (Only complete if prior authorization assistance is requested.)**

Is this patient currently receiving this drug? ☐ Yes ☐ No
Is this patient receiving dialysis treatment for treatment of chronic kidney disease? ☐ Yes ☐ No
Does this patient have a parathyroid hormone level (iPTH) of at least 300 pg/mL? ☐ Yes ☐ No
Is this drug continuing to provide clinical benefit for this patient (e.g., decrease in or maintenance of parathyroid hormone level and/or serum calcium level, serum phosphorus level, calcium-phosphorus product)? ☐ Yes ☐ No
Patient's previous or current medical treatment for secondary hyperparathyroidism includes:
☐ Calcium supplement (most recent date and name) ____________________
☐ Vitamin D sterol (most recent date and name) ____________________
☐ Phosphate binder (most recent date and name) ____________________

Statement of Medical Necessity: Primary Diagnosis and Date, Intact PTH Level, Serum Calcium, and Serum Phosphorous

Additional Lab Values or other supporting information to establish medical necessity: ____________________

I certify that Sensipar® therapy is necessary for this patient. I will be supervising the patient's treatment accordingly.
Physician's Signature ____________________
Date____________________

This verification of benefits is not a guarantee of payment by the payor, but is deemed as current coverage information as relayed by the payor to the Amgen Reimbursement Connection®. This verification cannot take the place of written policy information from the payor. *©2009 Amgen. All rights reserved.*

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I agree to permit my healthcare 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 any Amgen products that may be prescribed to me during my treatment (collectively, "Amgen Products"),
- 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 not be able 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 or faxing to 1-888-508-8090. 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 10 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

DO NOT FAX BACK THIS PAGE

Sensipar® (cinacalcet) Indication and Important Safety Information

Indication

Sensipar® is indicated for the treatment of secondary hyperparathyroidism (HPT) in patients with chronic kidney disease on dialysis.

Important Safety Information

Significant reductions in calcium may lower the threshold for seizures. Secondary hyperparathyroidism (HPT) patients, particularly those with a history of seizure disorder, should be carefully monitored for the occurrence of low serum calcium or symptoms of hypocalcemia.

In Sensipar® postmarketing use, isolated, idiosyncratic cases of hypotension, worsening heart failure, and/or arrhythmia were reported in patients with impaired cardiac function. The causal relationship to Sensipar® therapy could not be completely excluded and may be mediated by reductions in serum calcium levels.

Sensipar® lowers serum calcium; therefore, it is important that patients have a serum calcium ≥ 8.4 mg/dL when initiating therapy.

Adynamic bone disease may develop if intact parathyroid hormone (iPTH) levels are suppressed below 100 pg/mL.

Patients with moderate to severe hepatic impairment should be monitored throughout treatment with Sensipar®, as cinacalcet exposure assessed by area under the curve (AUC) was higher than in patients with normal hepatic function.

Serum calcium and serum phosphorus should be measured within 1 week and PTH should be measured 1 to 4 weeks after initiation or dose adjustment of Sensipar®. Once the maintenance dose has been established, serum calcium and serum phosphorus should be measured approximately monthly, and PTH every 1 to 3 months.

The most commonly reported side effects were nausea, vomiting, and diarrhea.

Please refer to www.sensipar.com for prescribing information.