AMGEN Support+

ENROLLMENT FORM

Select program enrollment:

- ☐ **Amgen Patient Navigator Program**
- ☐ **Benefits Verification**
- ☐ **Both**

COMPLETE all relevant fields and submit pages 1-2 to Amgen SupportPlus at **1-888-407-9787**.

Patient Information

First Name _____ MI ____ Last Name _____ Gender ☐ F ☐ M

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Patient Email _____ Date of Birth ___/___/_____

Alternate Contact /Caregiver Information

First Name _____ Last Name _____ Phone Number _____

Caregiver Email _____ Relationship to Patient _____

☐ By checking this box, I agree that it is acceptable to leave a message with this alternate caregiver.

Amgen Patient Navigator Program* (to be completed by patient)

The Amgen Patient Navigator is part of your Amgen SupportPlus support team. Amgen Patient Navigators can provide resources to help you access your medication, navigate your treatment journey, and provide support as you continue on your therapy as prescribed.

*Patient Navigators are only available to patients that are prescribed certain Amgen products. They are not part of your treatment team and do not provide medical advice, nursing, or case management services. Patient Navigator will not inject patients with Amgen medications. Patients should always consult their healthcare provider regarding medical decisions or treatment concerns.

CONSENT TO HEALTH DATA PROCESSING FOR AMGEN SupportPlus PROGRAM – REQUIRED

You must read the Consent to Health Data Processing on page 5 and then select one of the below responses. Select "I consent" to proceed with enrollment. If you select "I do not consent," you will not be able to continue enrolling in the Amgen SupportPlus Program.

- ☐ I consent to the collection, processing, and disclosure of my Health Data for the purposes set forth on page 5.
- ☐ I do not consent to the collection, processing, or disclosure of my Health Data for the purposes set forth on page 5.

PATIENT AUTHORIZATION – REQUIRED

By signing below, I am indicating that I have read and understood the Authorization for Use and Disclosure of Protected Health Information on page 3, that I am legally authorized to consent, and that I am providing my consent as the patient or the patient's legal representative for Amgen and its contractors and business partners to use and share the personal information I provide for the purposes described within the Authorization for Use and Disclosure of Protected Health Information.

Date _____ Printed Name of Patient _____ Signature of Patient _____

(If needed)
Name of Legal Representative _____ Signature of Legal Representative _____

Prescriber Attestation

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.

For any questions, please call (866) 264-2778.

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Insurance Information

Patient Primary 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 # _____ Payer Specific Provider Number _____

Treating Physician and Site Information

Physician Name
(if different from the prescriber) _____ State Where Licensed _____ State License # _____

Facility Name _____ Facility NPI # _____ Facility Tax ID # _____

Facility Address _____ City _____ State _____ Zip _____

Primary Contact Name _____ Title/Role _____

Primary Phone # _____ Primary Fax # _____ Primary Email _____

Site of Care: ☐ Prescriber Office/Clinic ☐ Hospital Outpatient ☐ Hospital Inpatient

☐ Home Health/Home Infusion. Home Health Agency Name (Optional) _____

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.

Medication and Coding Information* *(Check the medication(s) the patient has been prescribed.)*

Product	HCPCS Codes	ICD/Dx	Secondary ICD Code	Tertiary ICD Code
☐ BLINCYTO® (blinatumomab) injection	J9039			
☐ IMDELLTRA™ (tarlatamab-dlle) injection	J9026			

*For a full list of codes, refer to the Centers for Medicare & Medicaid Services Index.[1,2]

References: 1. Centers for Medicare & Medicaid Services. October 2025 Alpha-Numeric HCPCS File. Page last modified September 8, 2025. Accessed September 9, 2025. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update. **2.** Centers for Medicare & Medicaid Services. CMS Manual System. Transmittal 3685. Accessed September 9, 2025. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3685CP.pdf.

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.

Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for BLINCYTO® at BLINCYTOhcp.com
Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for IMDELLTRA™ at IMDELLTRAhcp.com.

For any questions, please call (866) 264-2778.

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AMGEN

Authorization for Use and Disclosure of Protected Health Information

Uses and Disclosure of Protected Health Information

I authorize Amgen and its data processors (collectively, "Amgen") to collect, use, and disclose my protected health information for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in the Amgen SupportPlus program or any other Amgen-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse partner services, adherence program and disease management support);
- To contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care;
- To improve, develop, and evaluate Amgen's products, services, materials and programs related to my condition or treatment.

In order for Amgen to provide me with the services and/or programs described above, Amgen needs to collect and use my personal information, including my protected health information. I understand that my protected health information may include any information, in electronic or physical form, in the possession of or derived from a health care provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor (each, a "Health Care Provider"). This may include select information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I authorize my Health Care Providers to disclose my protected health information to, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing my protected health information and/or for using my information to contact me with communications about Amgen products which have been prescribed to me (for example, medication reminder programs and other patient support services).

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Expiration, Right to Obtain a Copy, and Right to Cancel

I understand that by signing this form, I authorize my Health Care Providers or others who might hold my health information to disclose it to Amgen. I also understand I am authorizing my personal information, including my protected health information, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to disclose my protected health information for the earlier of five (5) years or until my participation in the Amgen SupportPlus program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling Amgen at (866) 264-2778 or by writing to Amgen SupportPlus, 2202 N. Westshore Blvd Ste. 650, Tampa, FL 33607. If I cancel this Authorization, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my protected health information to Amgen in reliance on this Authorization on an on-going basis, my cancellation with Amgen will be effective with respect to any such Health Care Providers as soon as they receive notice of my cancellation.

No Effect on Treatment

I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary. I understand that Amgen, as well as Health Care Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment or other care, to sign this Authorization. Federal Law (including HIPAA) requires a signed authorization in order for Amgen to collect my protected health information from my Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

Information Received from Health Care Providers

I understand that once my protected health information has been disclosed to Amgen, federal privacy laws may no longer apply and may no longer protect it from further disclosure, and that Amgen may disclose my protected health information to its data processors, contractors, and business partners for its business purposes. Amgen agrees, however, to protect my protected health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

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Consent to Health Data Processing for Amgen SupportPlus

I consent to Amgen processing my Health Data for the following purposes:

To enroll me and manage my participation in the Amgen SupportPlus program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, nurse partner support, disease management support), and to manage Amgen's products, services, and programs related to my condition or treatment.

Amgen uses the following when it administers the Amgen SupportPlus program:

Health Data – my name (and the name of my caregiver if applicable), gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that my consent to processing is required for me to participate in the Amgen SupportPlus program. I also understand that Amgen will not sell my Health Data to third parties, but may disclose my Health Data to Amgen's data processors, contractors, and business partners for Amgen's business purposes related to the Amgen SupportPlus program. I understand that Amgen may use my Health Data to contact me by mail, email, telephone, or text for the above purposes. I also understand that if I do not consent to the use of my Health Data for the above purposes, I will not be able to participate in the Amgen SupportPlus program. Finally, I understand that I may withdraw my consent to processing my Health Data for the above purposes at any time using one of the methods listed in the Additional Disclosures section below and that if I withdraw my consent, I will no longer be able to participate in the Amgen SupportPlus program.

Additional Disclosures

I understand that participation in the Amgen SupportPlus program and, if I have consented, receipt of marketing communications are optional services at no cost to me. The consent(s) above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications. To obtain a copy of the consent(s) above or to withdraw my consent to collection, processing, and/or disclosure of my Health Data for any of the above purposes to which I have consented, I can contact Amgen by visiting www.amgen.com/DataSubjectRights or calling (866) 264-2778. For more information about Amgen's privacy practices, Amgen's Privacy Statement can be found at http://www.amgen.com/privacy.

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