AMGEN ASSIST 360™
Support, Simplified

BENEFIT VERIFICATION REQUEST FORM

Please fill in the following 2 pages if you are a healthcare provider requesting insurance verification.

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		Patient Secondary Insurance Information	
Insurance Name		Insurance Name	
Policy #		Policy #	
Policy Holder Name		Policy Holder Name	
Date of Birth		Date of Birth	
Relation to Patient		Relation to Patient	
Insurance Phone #		Insurance Phone #	
Group #		Group #	

PRESCRIBER INFORMATION

Prescriber Name   State Where Licensed   State License #

NPI#   Tax ID#

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

Payer Specific Provider Number

Facility Name   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

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.

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For any questions, please call **888-4ASSIST** (888-427-7478)
Please fax completed forms to Amgen Assist 360™ at **888-407-9787**

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MEDICATION AND CODING INFORMATION *(Check the medication(s) the patient has been prescribed.) Section 1, cont'd.*

Product	HCPCS Codes	ICD/Dx	Secondary ICD code	Tertiary ICD code
☐ Aranesp® (darbepoetin alfa) injection	J0881			
☐ BLINCYTO® (blinatumomab) injection	J9039			
☐ IMLYGIC® (talimogene laherparepvec) suspension for injection	J9325			
☐ KANJINTI™ (trastuzumab-anns) for injection Treatment naive? ☐ Yes ☐ No	Q5117			
☐ KYPROLIS® (carfilzomib) for injection	J9047			
☐ MVASI™ (bevacizumab-awwb) for injection Treatment naive? ☐ Yes ☐ No	Q5107			
☐ Neulasta® (pegfilgrastim) Onpro® kit injection	J2505			
☐ Neulasta® (pegfilgrastim) prefilled syringe injection	J2505			
☐ NEUPOGEN® (filgrastim) injection	J1442			
☐ Nplate® (romiplostim) injection	J2796			
☐ Prolia® (denosumab) injection	J0897			
☐ RIABNI™ (rituximab-arrx)	J3490/C9399			
☐ Vectibix® (panitumumab) injection for IV infusion	J9303			
☐ XGEVA® (denosumab) injection	J0897			

Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for Aranesp® at aranesp.com.
Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for BLINCYTO® at blincyto.com.
Please see Full Prescribing Information, including **Boxed WARNINGS**, for KANJINTI™ at kanjinti.com.
Please see Full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for RIABNI™ at riabni.com.
Please see Full Prescribing Information, including **Boxed WARNINGS**, for Vectibix® at vectibix.com.

For a full list of codes, refer to the Centers for Medicare & Medicaid Services 2017 Index[1,2]

References: 1. Centers for Medicare & Medicaid Services. 2020 Alpha-Numeric HCPCS File. Available at: https://www.cms.gov/Medicare/Coding/HCPCS ReleaseCodeSets/Downloads/2020-HCPCS-Index.pdf. Accessed October 8, 2020. **2.** Centers for Medicare & Medicaid Services. CMS Manual System. Transmittal 3685. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3685CP.pdf. Accessed October 8, 2020.

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.)_____

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