Insurance Verification Form

Fax with copies of insurance card(s), front and back, to Amgen® SupportPlus: 1-877-877-6542

prolia® (denosumab) injection

Patient Information ❑ New Patient to Prolia® ❑ Existing Patient

*Patient Name: _____

❑ Attach patient demographic sheet **OR** Complete information below:

*Street Address: _____

*City: _____ *State:_____ *ZIP: _____

*Phone: _____

M ❑ F ❑ *Date of Birth: _____

Fulfillment Method (Select only ONE)

❑ Medical Benefit (Physician Purchase)

❑ Pharmacy Benefit ❑ Out of Network Benefits

❑ Referral to treating site:

*Enter Site ID: _____ **OR** Complete information below.

*Site Name: _____

*Street Address: _____

*City: _____ *State:_____ *ZIP: _____

*Phone: _____ *Fax: _____

Office Contact: _____

*Site Type: ❑ MD Office ❑ Hospital Outpatient

Primary Insurance Information

❑ Attach a copy of insurance card, front AND back **OR** provide:

*Insurance Name: _____

*Insurance Phone:_____

Subscriber Name: _____

Subscriber Date of Birth:_____

Subscriber Relationship to Patient:_____

Group #: _____

*Policy #: _____

Medicare Beneficiary Identifier: _____

Secondary Insurance Information (If Applicable)

❑ Attach a copy of insurance card, front AND back **OR** provide:

*Insurance Name: _____

*Is this a Medigap policy? ❑ Yes ❑ No ❑ Not Known

If yes, please indicate plan letter: _____

*Insurance Phone:_____

Subscriber Name: _____

Subscriber Date of Birth:_____

Subscriber Relationship to Patient:_____

Group #: _____

*Policy #: _____

Pharmacy Insurance Information

❑ Attach a copy of insurance card, front AND back **OR** provide:

*Pharmacy Insurance Patient ID #:_____

*Pharmacy Insurance Phone #: _____

*Asterisk fields are required for processing.

Physician Information

*Physician Name: _____

*NPI #: _____ Tax ID #: _____

Specialty: _____

*Enter Site ID: _____ **OR** Complete information below.

*Site NPI #: _____ Site Tax ID #: _____

*Site Name: _____

*Street Address: _____

*City: _____ *State:_____ *ZIP: _____

*Phone: _____ Fax: _____

Office Contact: _____

*Site Type: ❑ MD Office ❑ Hospital Outpatient

Patient Medical Information†

❑ M81.0 (Age-related osteoporosis without current pathological fracture)

❑ M80.0 _____ (Age-related osteoporosis with current pathological fracture...) Please provide complete code

❑ Other (specify ICD Code) _____

Please provide secondary ICD Code, if applicable: _____

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.

†The sample diagnosis codes are informational and not intended to be directive or a guarantee of reimbursement and include potential codes that would include FDA approved indications for Prolia®. Other codes may be more appropriate given internal system guidelines, payer requirements, practice patterns, and the services rendered.

Prescription Information

Prolia® 60 mg pre-filled syringe, 60 mg SC every 6 months

Refill: ❑ x1

Prescriber Signature: (required for legal prescription triage)

✗ _____Date: _____

Injection Date

Patient's Scheduled Injection Date: _____

OPTIONAL: 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.

If you have any questions, please contact Amgen SupportPlus at 1-866-264-2778.

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.

Fax Completed Form and/or Copy of Insurance Card(s) to Amgen SupportPlus: 1-877-877-6542.

EVENITY®
(romosozumab-aqqg)
injection 105 mg/1.17 mL

Insurance Verification Form

Fax with copies of insurance card(s), front and back, to Amgen® SupportPlus: 1-877-877-6542

Patient Information ☐ New Patient to EVENITY® ☐ Existing Patient

*Patient Name: _____

☐ Attach patient demographic sheet **OR** Complete information below.

*Street Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone: _____

M ☐ F ☐ *Date of Birth: _____

Fulfillment Method (Select only ONE)

☐ Medical Benefit (Physician Purchase) ☐ Out of Network Benefits

☐ Referral to treating site:

*Enter Site ID: _____ **OR** Complete information below.

*Site Name: _____

*Street Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone: _____ *Fax: _____

Office Contact: _____

*Site Type: ☐ MD Office ☐ Hospital Outpatient

Primary Insurance Information

☐ Attach a copy of insurance card, front AND back **OR** provide:

*Insurance Name: _____

*Insurance Phone: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Relationship to Patient: _____

Group #: _____

*Policy #: _____

Medicare Beneficiary Identifier: _____

Secondary Insurance Information (If Applicable)

☐ Attach a copy of insurance card, front AND back **OR** provide:

*Insurance Name: _____

*Is this a Medigap policy? ☐ Yes ☐ No ☐ Not Known

If yes, please indicate plan letter: _____

*Insurance Phone: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber Relationship to Patient: _____

Group #: _____

*Policy #: _____

Prescription Information

EVENITY® 210 mg SC every month for 12 doses

Prescriber Signature: (required for legal prescription triage)

_____ Date: _____

*Asterisk fields are required for processing.

Physician Information

*Physician Name : _____

*NPI #: _____ Tax ID #: _____

Specialty: _____

*Enter Site ID: _____ **OR** Complete information below.

*Site NPI #: _____ Site Tax ID #: _____

*Site Name: _____

*Street Address: _____

*City: _____ *State: _____ *ZIP: _____

*Phone: _____ Fax: _____

Office Contact: _____

*Site Type: ☐ MD Office ☐ Hospital Outpatient

Patient Medical Information†

☐ M80.0 ____ (Age-related osteoporosis with current pathological fracture...) Please provide complete code

☐ M81.0 (Age-related osteoporosis without current pathological fracture)

☐ Other (specify ICD Code)

Please provide secondary ICD Code, if applicable: _____

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Continued Therapy

The anabolic effect of EVENITY® wanes after 12 monthly doses of therapy. Consider whether continued therapy with an anti-resorptive is warranted after the end of the EVENITY® treatment.

Would you like to be notified when your patient nears the end of their EVENITY® treatment for a reminder regarding a follow-up anti-resorptive treatment such as Prolia® (denosumab)? ☐ Yes ☐ No

OPTIONAL: Affordability Screening

To see if the patient is eligible for additional affordability options, please complete the questions below.

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How many people live in the patient's household (including the patient)?:

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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.

If you have any questions, please contact Amgen SupportPlus at 1-866-264-2778.

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