



1-800-272-9376 (telephone)
1-888-508-8090 (fax)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____ (“Patient”), 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.

Company may also share information about me with Amgen’s Safety Net Foundation or other independent third party patient assistance foundations for the purposes of determining whether I am eligible for a patient assistance program. If it appears that I may be eligible for assistance, Amgen’s Safety Net Foundation or other third party patient assistance foundation may contact me or my Provider for the purpose of beginning the application process for any such patient assistance programs.

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 do not, 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