



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

Insurance Verification Request Form for Kepivance™

Please complete this form and fax it to 1-888-508-8090 for processing. Incomplete information may delay results.

Physician/Facility Information

Contact/Requestor Name, Facility Name, Treating Physician's Name, Tax ID #, Physician Specialty, Phone #, Fax #, Address, City, State, Zip, RC Sponsor #

Requestor Preferences

Please check all settings of care you would like researched: Hospital Inpatient, Hospital Outpatient, Other, Phone, Fax, No preference

Patient General Information

Patient Name, Patient State & Zip Code, Patient Phone Number, Patient DOB, Social Security #

Patient Medical Information

Dose, Frequency, Diagnosis Code(s), Type of transplant, Setting of Service, Bone Marrow Transplant (BMT), Peripheral Blood Stem Cell Transplant, Hospital Inpatient, Hospital Outpatient, Other

Primary Insurance If Medicaid, please include the Medicaid provider #

Insurer Name, Insurer State, Insurer Fax Number, Policyholder's Name, Policyholder's SSN, Policyholder's DOB, Relationship to patient, Insurer Phone Number, Provider # for this Policy, Policy Number, Group/Plan Number

Secondary Insurance\* If Medicaid, please include the Medicaid provider #

Insurer Name, Insurer State, Insurer Fax Number, Policyholder's Name, Policyholder's SSN, Policyholder's DOB, Relationship to patient, Insurer Phone Number, Provider # for this Policy, Policy Number, Group/Plan Number

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.

\* Complete only if different from primary insurance information.

## **AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

I agree to permit my health care 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 \_\_\_\_\_ (drug name), and any other Amgen products that may be prescribed to me during my treatment (collectively, “Amgen Products”),
- and 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 be unable 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. 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 ten 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