

# RAVICTI® (glycerol phenylbutyrate) PATIENT ENROLLMENT FORM INSTRUCTIONS

The RAVICTI Patient Enrollment Form is required to initiate treatment with an Amgen urea cycle disorder (UCD) medicine.

## Instructions:

1. Complete all required patient information.
2. Complete all required insurance information for the patient and attach copies of the front and back of the patient's medical and prescription insurance cards.
3. Complete the diagnosis and prescription information in its entirety; all fields are required. The patient's healthcare provider should fill out this section.
4. Complete all required prescriber information, including the contact information for the practice or facility.
5. A signature is required from the patient's healthcare provider.
6. **Fax pages 1-4 of this form, along with both sides of the patient's medical and prescription drug benefit cards, to the Amgen By Your Side team at 1-877-695-8304 or email to [UCDABYS@amgen.com](mailto:UCDABYS@amgen.com).**
7. Check with your patient to ensure he or she has printed, signed, and dated the required Patient Consent and Authorization for Amgen By Your Side, in order to initiate patient support.
8. If you have any questions or comments, please contact Amgen By Your Side at **1-855-823-7878**.

# RAVICTI PATIENT ENROLLMENT FORM



Once complete, submit pages 1-4 by fax 1-877-695-8304 or email [UCDABYS@amgen.com](mailto:UCDABYS@amgen.com)

Initiate the patient enrollment process by completing ALL REQUIRED FIELDS indicated by \*.  
For patient support and/or assistance obtaining patient signature, call Amgen By Your Side at 1-855-823-7878.

USA-ABYS-80168 10/25

## 1. PATIENT INFORMATION

First name*	Last name*	Primary language		
Address*	City*	State*	ZIP*	
Mobile phone*	<input type="radio"/> Primary	Home phone*	<input type="radio"/> Primary	
Email*	Date of birth* (MM/DD/YYYY)		Gender*: <input type="radio"/> Male <input type="radio"/> Female	

## ALTERNATIVE CONTACT AND/OR CAREGIVER

First name	Last name	Email		
Mobile phone	<input type="radio"/> Primary	Home phone	<input type="radio"/> Primary	Relationship to patient

## 2. INSURANCE INFORMATION

Please attach copies of the front and back of patient's medical and prescription insurance cards.

No Insurance

Primary insurance*	Secondary insurance
Insurance company phone*	Insurance company phone
Policy type*: <input type="radio"/> Commercial <input type="radio"/> Medicaid <input type="radio"/> Medicare <input type="radio"/> Other	Policy type: <input type="radio"/> Commercial <input type="radio"/> Medicaid <input type="radio"/> Medicare <input type="radio"/> Other
Policy #*	Group #*
Policyholder name*	Policyholder name
Relationship*	Relationship
Policyholder's date of birth* (MM/DD/YYYY)	Policyholder's date of birth (MM/DD/YYYY)
Prescription card*: <input type="radio"/> Yes <input type="radio"/> No	Phone
Identification #	Policy/Group #
Policyholder name	Relationship
	Policyholder's date of birth (MM/DD/YYYY)

## 3. DIAGNOSIS

Ornithine transcarbamylase deficiency/OTC (E72.4)  Argininosuccinate lyase deficiency/ASL (E72.22)  Argininemia/ARG (E72.21)

Carbamoyl phosphate synthetase/CPS (E72.29)  Citrullinemia/ASSD (E72.23)

Hyperammonemia-hyperornithinemia-homocitrullinuria syndrome/HHH (E72.4)  Disorder of urea cycle metabolism, unspecified (E72.20)

Other diagnosis, ICD-10 \_\_\_\_\_ Please visit [www.icd10data.com/Convert/270.6](http://www.icd10data.com/Convert/270.6) for more information.

Current Nitrogen Scavenger:  Sodium phenylbutyrate  Sodium benzoate  Sodium phenylbutyrate and sodium benzoate

No nitrogen scavenger

Complete signatures and prescription information on next page



## 4. PATIENT CONSENT AND AUTHORIZATION (Required - please see language on pages 3-4)

USA-ABYS-80168 10/25

You must read the Consent to Health Data Processing on page 4 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 enroll in Amgen By Your Side.

- I consent to the collection, processing, and disclosure of my Health Data for the purposes set forth on page 4.**
- I do not consent to the collection, processing, or disclosure of my Health Data for the purposes set forth on page 4.**

By signing below, I am indicating that I have read and understood the Authorization for Use and Disclosure of Protected Health Information (pages 3-4), 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.

Patient name\*

Name of Legal Representative (if applicable)



Signature of patient (or Legal Representative)\*

Date\* (MM/DD/YYYY)

## 5. PRESCRIPTION INFORMATION

Patient first name\*

Patient last name\*

Date of Birth\* (MM/DD/YYYY)

RAVICTI® (glycerol phenylbutyrate) Oral Liquid, 1.1 g/mL Allergies\*: \_\_\_\_\_ or  No known drug allergies (NKDA)

Patient weight\*: \_\_\_\_\_ lbs OR \_\_\_\_\_ kg Patient height\*: \_\_\_\_\_  in  cm

Dose\*

Doses per Day\*

Total Daily Dose\*

Days' Supply\*

Total Quantity\*

# Refills\*

Instructions\*

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

## 6. PRESCRIBER INFORMATION

Preferred Method of Contact  Email  Phone

First name\*

Last name\*

Credentials

NPI #\*

State license #\*

State issued\*

Tax ID\*

Specialty

Practice/Facility name\*

Office contact name\*

Address\*

City\*

State\*

ZIP\*

Office contact phone\*

Fax\*

Office contact email\*

**Signature below indicates prescription authorization and prescriber certification.**

Prescriber Signature\* (sign one line ONLY)

Written or e-signature only; stamps not acceptable.



Dispense as written

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



Substitutions permitted

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

For Providers in **Texas & Florida** ONLY:

For prescriptions in which the brand intends to be dispensed, please handwrite "Brand Medically Necessary" in the box provided:

**Prescriber Certification:** I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge and that my patient is being administered RAVICTI in accordance with the labeled use of the product. I represent that my patient has requested and authorized the disclosure of their personal information to Amgen, Inc. and its affiliates and their respective employees or agents (collectively, "Amgen") for Amgen to administer the Amgen By Your Side program (the "Program"), which provides patient-focused support, including providing logistical and non-medical treatment support for RAVICTI as prescribed, and educating about the insurance process. I further represent that I have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Amgen will use the patient's name, date of birth, contact information, prescriptions, and other necessary health information to administer the Program; 2) Amgen will then disclose the patient's personal information to the patient's insurer(s) for the same purposes; 3) the patient can withdraw their consent by contacting Amgen at 1-844-469-4297 or visiting [www.amgen.com/DataSubjectRights](http://www.amgen.com/DataSubjectRights), but if the patient does not agree to, or withdraws consent for, these uses and disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Amgen to process the patient's personal information; and 4) the patient can view more details about Amgen's privacy practice at [www.amgen.com/privacy](http://www.amgen.com/privacy). I authorize Amgen to transmit this prescription on my behalf to the appropriate pharmacy designated by the patient utilizing their benefit plan by any means allowed under applicable law. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use RAVICTI or any other Amgen product or service, for any other person; (b) my decision to prescribe RAVICTI was based solely on my professional determination of medical necessity; and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Amgen may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Amgen makes no representation or guarantee concerning coverage or reimbursement for any item or service.

State requirements: I certify that the prescription I am submitting as part of this Patient Enrollment Form complies with my state's prescription requirements (e.g., e-prescribing, state-specific prescription form, fax language). I understand that noncompliance with my state's specific prescription requirements will result in outreach to me to obtain a compliant prescription.

By filling out and signing this form, the enrollment process in Amgen By Your Side has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Amgen By Your Side. Please note that your patient will not benefit from the services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Amgen will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

**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 By Your Side 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, patient access liaison 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 Amgen, 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).

**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 By Your Side 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 1-844-469-4297 or by writing to Amgen By Your Side, 1 Horizon Way, Deerfield, IL 60015. 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.

**U.S. STATE LAW CONSENT TO PROCESS HEALTH DATA FOR AMGEN BY YOUR SIDE**

Please read and provide response in Patient Consent and Authorization section on page 2.

**Consent to Health Data Processing for Amgen By Your Side**

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

- To enroll me and manage my participation in the Amgen By Your Side program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, patient access liaison 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 By Your Side 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 By Your Side program. I also understand that Amgen will not sell my Health Data to third parties, but Amgen may disclose my Health Data to Amgen's data processors, contractors, and business partners for Amgen's business purposes related to the Amgen By Your Side program. I understand that Amgen may use my Health Data to contact me by mail, email, telephone, or text for the above purposes. Mobile Terms & Conditions can be found at [AmgenByYourSide.com/mobile-terms-and-conditions](http://AmgenByYourSide.com/mobile-terms-and-conditions). 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 By Your Side 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 By Your Side program.

**Additional Disclosures**

I understand that participation in the Amgen By Your Side program is an optional service at no cost to me. The consent 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 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](http://www.amgen.com/DataSubjectRights) or calling 1-844-469-4297. For more information about Amgen's privacy practices, Amgen's Privacy Statement can be found at <http://www.amgen.com/privacy>

Once complete, submit pages 1-4 by fax 1-877-695-8304 or email [UCDABYS@amgen.com](mailto:UCDABYS@amgen.com)



# RAVICTI® (glycerol phenylbutyrate) PATIENT ENROLLMENT FORM INSTRUCTIONS

The RAVICTI Patient Enrollment Form is required to initiate treatment with an Amgen urea cycle disorder (UCD) medicine.

## Instructions:

1. Complete all required patient information.
2. Complete all required insurance information for the patient and attach copies of the front and back of the patient's medical and prescription insurance cards.
3. Complete the diagnosis and prescription information in its entirety; all fields are required. The patient's healthcare provider should fill out this section.
4. Complete all required prescriber information, including the contact information for the practice or facility.
5. A signature is required from the patient's healthcare provider.
6. **Fax pages 1-4 of this form, along with both sides of the patient's medical and prescription drug benefit cards, to the Amgen By Your Side team at 1-877-695-8304 or email to [UCDABYS@amgen.com](mailto:UCDABYS@amgen.com).**
7. Check with your patient to ensure he or she has printed, signed, and dated the required Patient Consent and Authorization for Amgen By Your Side, in order to initiate patient support.
8. If you have any questions or comments, please contact Amgen By Your Side at **1-855-823-7878**.

# RAVICTI PATIENT ENROLLMENT FORM



Once complete, submit pages 1-4 by fax 1-877-695-8304 or email [UCDABYS@amgen.com](mailto:UCDABYS@amgen.com)

Initiate the patient enrollment process by completing ALL REQUIRED FIELDS indicated by \*.  
For patient support and/or assistance obtaining patient signature, call Amgen By Your Side at 1-855-823-7878.

USA-ABYS-80168 10/25

## 1. PATIENT INFORMATION

First name*	Last name*	Primary language		
Address*	City*	State*	ZIP*	
Mobile phone*	Primary	Home phone*	Primary	
Email*	Date of birth* (MM/DD/YYYY)		Gender*: Male Female	

## ALTERNATIVE CONTACT AND/OR CAREGIVER

First name	Last name	Email		
Mobile phone	Primary	Home phone	Primary	Relationship to patient

## 2. INSURANCE INFORMATION

Please attach copies of the front and back of patient's medical and prescription insurance cards.

No Insurance

<b>Primary insurance*</b>	Secondary insurance
<b>Insurance company phone*</b>	Insurance company phone
<b>Policy type*:</b> Commercial Medicaid Medicare Other	<b>Policy type:</b> Commercial Medicaid Medicare Other
<b>Policy #*</b> <b>Group #*</b>	<b>Policy #</b> <b>Group #</b>
<b>Policyholder name*</b>	Policyholder name
<b>Relationship*</b>	<b>Policyholder's date of birth*</b> (MM/DD/YYYY)
<b>Prescription card*:</b> Yes No	Relationship
If yes, carrier	Policyholder's (MM/DD/YYYY) date of birth
Phone	
Identification #	Policy/Group #
Policyholder name	Relationship
	Policyholder's (MM/DD/YYYY) date of birth

## 3. DIAGNOSIS

Ornithine transcarbamylase deficiency/OTC (E72.4)      Argininosuccinate lyase deficiency/ASL (E72.22)      Argininemia/ARG (E72.21)  
Carbamoyl phosphate synthetase/CPS (E72.29)      Citrullinemia/ASSD (E72.23)  
Hyperammonemia-hyperornithinemia-homocitrullinuria syndrome/HHH (E72.4)      Disorder of urea cycle metabolism, unspecified (E72.20)  
Other diagnosis, ICD-10 \_\_\_\_\_ Please visit [www.icd10data.com/Convert/270.6](http://www.icd10data.com/Convert/270.6) for more information.

Current Nitrogen Scavenger:      Sodium phenylbutyrate      Sodium benzoate      Sodium phenylbutyrate and sodium benzoate  
No nitrogen scavenger

Complete signatures and prescription information on next page



## 4. PATIENT CONSENT AND AUTHORIZATION (Required - please see language on pages 3-4)

USA-ABYS-80168 10/25

You must read the Consent to Health Data Processing on page 4 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 enroll in Amgen By Your Side.

- I consent to the collection, processing, and disclosure of my Health Data for the purposes set forth on page 4.**  
 **I do not consent to the collection, processing, or disclosure of my Health Data for the purposes set forth on page 4.**

By signing below, I am indicating that I have read and understood the Authorization for Use and Disclosure of Protected Health Information (pages 3-4), 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.

Patient name\* \_\_\_\_\_ Name of Legal Representative (if applicable) \_\_\_\_\_  
 Signature of patient (or Legal Representative)\* \_\_\_\_\_ Date\* (MM/DD/YYYY) \_\_\_\_\_

## 5. PRESCRIPTION INFORMATION

Patient first name\* \_\_\_\_\_ Patient last name\* \_\_\_\_\_ Date of Birth\* (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
RAVICTI® (glycerol phenylbutyrate) Oral Liquid, 1.1 g/mL Allergies\*: \_\_\_\_\_ or No known drug allergies (NKDA)  
Patient weight\*: \_\_\_\_\_ lbs OR \_\_\_\_\_ kg Patient height\*: \_\_\_\_\_ in cm  
Dose\* \_\_\_\_\_ Doses per Day\* \_\_\_\_\_ Total Daily Dose\* \_\_\_\_\_ Days' Supply\* \_\_\_\_\_

Total Quantity\* \_\_\_\_\_ # Refills\* \_\_\_\_\_ Instructions\* \_\_\_\_\_  
State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

## 6. PRESCRIBER INFORMATION

Preferred Method of Contact  Email  Phone

First name\* \_\_\_\_\_ Last name\* \_\_\_\_\_ Credentials \_\_\_\_\_  
NPI #\* \_\_\_\_\_ State license #\* \_\_\_\_\_ State issued\* \_\_\_\_\_ Tax ID\* \_\_\_\_\_ Specialty \_\_\_\_\_  
Practice/Facility name\* \_\_\_\_\_ Office contact name\* \_\_\_\_\_  
Address\* \_\_\_\_\_ City\* \_\_\_\_\_ State\* \_\_\_\_\_ ZIP\* \_\_\_\_\_  
Office contact phone\* \_\_\_\_\_ Fax\* \_\_\_\_\_ Office contact email\* \_\_\_\_\_

**Signature below indicates prescription authorization and prescriber certification.**

**Prescriber Signature\* (sign one line ONLY)**

Written or e-signature only; stamps not acceptable.

\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*Dispense as written* *Substitutions permitted*

For Providers in **Texas & Florida ONLY**:  
For prescriptions in which the brand intends to be dispensed,  
please handwrite "Brand Medically Necessary" in the box provided:

**Prescriber Certification:** I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge and that my patient is being administered RAVICTI in accordance with the labeled use of the product. I represent that my patient has requested and authorized the disclosure of their personal information to Amgen, Inc. and its affiliates and their respective employees or agents (collectively, "Amgen") for Amgen to administer the Amgen By Your Side program (the "Program"), which provides patient-focused support, including providing logistical and non-medical treatment support for RAVICTI as prescribed, and educating about the insurance process. I further represent that I have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Amgen will use the patient's name, date of birth, contact information, prescriptions, and other necessary health information to administer the Program; 2) Amgen will then disclose the patient's personal information to the patient's insurer(s) for the same purposes; 3) the patient can withdraw their consent by contacting Amgen at 1-844-469-4297 or visiting [www.amgen.com/DataSubjectRights](http://www.amgen.com/DataSubjectRights), but if the patient does not agree to, or withdraws consent for, these uses and disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Amgen to process the patient's personal information; and 4) the patient can view more details about Amgen's privacy practice at [www.amgen.com/privacy](http://www.amgen.com/privacy). I authorize Amgen to transmit this prescription on my behalf to the appropriate pharmacy designated by the patient utilizing their benefit plan by any means allowed under applicable law. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use RAVICTI or any other Amgen product or service, for any other person; (b) my decision to prescribe RAVICTI was based solely on my professional determination of medical necessity; and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Amgen may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Amgen makes no representation or guarantee concerning coverage or reimbursement for any item or service.

State requirements: I certify that the prescription I am submitting as part of this Patient Enrollment Form complies with my state's prescription requirements (e.g., e-prescribing, state-specific prescription form, fax language). I understand that noncompliance with my state's specific prescription requirements will result in outreach to me to obtain a compliant prescription.

By filling out and signing this form, the enrollment process in Amgen By Your Side has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Amgen By Your Side. Please note that your patient will not benefit from the services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Amgen will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

**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 By Your Side 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, patient access liaison 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 Amgen, 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).

**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 By Your Side 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 1-844-469-4297 or by writing to Amgen By Your Side, 1 Horizon Way, Deerfield, IL 60015. 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.

**U.S. STATE LAW CONSENT TO PROCESS HEALTH DATA FOR AMGEN BY YOUR SIDE**

Please read and provide response in Patient Consent and Authorization section on page 2.

**Consent to Health Data Processing for Amgen By Your Side**

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

- To enroll me and manage my participation in the Amgen By Your Side program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, patient access liaison 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 By Your Side 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 By Your Side program. I also understand that Amgen will not sell my Health Data to third parties, but Amgen may disclose my Health Data to Amgen's data processors, contractors, and business partners for Amgen's business purposes related to the Amgen By Your Side program. I understand that Amgen may use my Health Data to contact me by mail, email, telephone, or text for the above purposes. Mobile Terms & Conditions can be found at [AmgenByYourSide.com/mobile-terms-and-conditions](http://AmgenByYourSide.com/mobile-terms-and-conditions). 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 By Your Side 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 By Your Side program.

**Additional Disclosures**

I understand that participation in the Amgen By Your Side program is an optional service at no cost to me. The consent 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 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](http://www.amgen.com/DataSubjectRights) or calling 1-844-469-4297. For more information about Amgen's privacy practices, Amgen's Privacy Statement can be found at <http://www.amgen.com/privacy>

Once complete, submit pages 1-4 by fax 1-877-695-8304 or email [UCDABYS@amgen.com](mailto:UCDABYS@amgen.com)

