

Specialty Pharmacy Intake Form

Please see Repatha™ Indications and Important Safety Information on page 2.

If an item does not apply, please note "N/A" on that line.

Fax with copies of insurance card(s), front and back, and appropriate information from patient's medical charts to the Specialty Pharmacy you have indicated below.



Patient Information

Patient Name*: _____	Preferred Phone*: () _____
Street Address*: _____	Email Address: _____
City*: _____ State*: _____ Zip*: _____	Date of Birth*: _____
	Social Security Number: _____

Pharmacy Insurance Information	Primary/Secondary Medical Insurance Information (ONLY if Pharmacy Insurance Information is not available)
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<input type="checkbox"/> Attach a copy of insurance card, front and back, AND provide: Pharmacy Insurance ID #: _____ Pharmacy Insurance Telephone*: () _____	<input type="checkbox"/> Attach a copy of insurance card, front and back, AND provide: Name of Insurer*: _____ Insurer Telephone: () _____ Group Number: _____ Policy Number*: _____
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Prescriber Information

Office Contact: _____	Office Street Address*: _____
Email Address: _____	City*: _____ State*: _____ Zip*: _____
Prescriber Name*: _____	Telephone*: () _____
Specialty: _____	Fax: () _____
Office Name*: _____	Prescriber NPI #*: _____

Prescription Information: Repatha™ (evolocumab)

Dose	Directions	Quantity	Refills
140 mg/mL SureClick®	Inject subcutaneously every two (2) weeks [†]	<input type="checkbox"/> 28 days <input type="checkbox"/> 84 days <input type="checkbox"/> _____ days	<input type="checkbox"/> _____ refills

Prescriber Signature (no stamps) (Dispense as Written): **X** _____ **Date:** _____

Prescriber Signature (no stamps) (Substitution Permitted): **X** _____ **Date:** _____

Specialty Pharmacy Options

<input type="checkbox"/> Accredo Health Group P: 1-855-315-6123 F: 1-800-837-0959	<input type="checkbox"/> Avella Specialty Program P: 1-877-546-5779 F: 1-877-546-5780	<input type="checkbox"/> Cigna Specialty Pharmacy Services P: 1-800-351-3606 F: 1-800-351-3616	<input type="checkbox"/> CVS Specialty P: 1-855-552-2017 F: 1-866-653-0224
<input type="checkbox"/> Diplomat Pharmacy, Inc. P: 1-855-611-3403 F: 1-855-423-8302	<input type="checkbox"/> Humana Pharmacy, Inc. P: 1-800-486-2668 F: 1-877-405-7940	<input type="checkbox"/> OptumRx P: 1-888-739-5820 F: 1-800-853-3844	<input type="checkbox"/> Prime Therapeutics Specialty Pharmacy P: 1-877-627-6337 F: 1-877-828-3939
<input type="checkbox"/> Senderra Rx P: 1-888-777-5547 F: 1-888-777-5645	<input type="checkbox"/> TLCRx/Modern Health Specialty Pharmacy P: 1-888-355-4191 F: 1-888-355-4192	<input type="checkbox"/> Walgreens Specialty Pharmacy P: 1-888-347-3416 F: 1-877-231-8302	<input type="checkbox"/> Alternate Specialty Pharmacy Name: _____ _____ P: _____ F: _____

*Required for processing.

[†]Note: Dosage for primary hyperlipidemia indication.

Please see page 4 for the RepathaReady™ Program Privacy Notice and Authorization, which must be signed by the patient or his or her legal guardian.

Repatha™ and RepathaReady™ are trademarks of Amgen Inc. All other marks used herein are the property of their respective owners.

RepathaReady™: Personalized support services for patients and providers.

By signing above, 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.

FOR SPECIALTY PHARMACY USE ONLY: RepathaReady™ Phone: 1-844-REPATHA (737-2842), Hours: 9 AM-9 PM ET, M-F;
Fax: 1-855-REPATHA (737-2842)



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USA-145-116415

Physician NPI #: _____

Patient Medical Information†			
Please provide one primary ICD-10-CM code*†: <input type="checkbox"/> E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)‡ <input type="checkbox"/> E78.2 Mixed Hyperlipidemia <input type="checkbox"/> E78.4 Other Hyperlipidemia <input type="checkbox"/> E78.5 Hyperlipidemia, Unspecified	Please provide one secondary ICD-10-CM code*†:		
	<input type="checkbox"/> I20.0 Unstable Angina <input type="checkbox"/> I20.9 Angina Pectoris, Unspecified <input type="checkbox"/> I21.____ Acute Myocardial Infarction <input type="checkbox"/> I22.____ Subsequent Myocardial Infarction <input type="checkbox"/> I25.____ Chronic Ischemic Heart Disease	<input type="checkbox"/> I63.____ Cerebral Infarction <input type="checkbox"/> I65.____ Occlusion and Stenosis of Cerebral Arteries, Extracranial <input type="checkbox"/> I66.____ Occlusion and Stenosis of Cerebral Arteries, Intracranial <input type="checkbox"/> I67.____ Other Cerebrovascular Diseases <input type="checkbox"/> I70.____ Atherosclerosis	<input type="checkbox"/> I73.9 Peripheral Vascular Disease, Unspecified <input type="checkbox"/> G45.9 Transient Cerebral Ischemic Attack, Unspecified <input type="checkbox"/> G46.____ Vascular Syndromes <input type="checkbox"/> Other (specify ICD-10-CM): _____ _____ _____
Treatment History (dose in mg)			
LDL-C on Treatment: _____ Date: _____ <input type="checkbox"/> Atorvastatin (Lipitor®) <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> 80 <input type="checkbox"/> Rosuvastatin (Crestor®) <input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> Simvastatin (Zocor®) <input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 40 <input type="checkbox"/> Ezetimibe (Zetia®) <input type="checkbox"/> 10 <input type="checkbox"/> Other statin/lipid-lowering medication(s): _____ _____ <input type="checkbox"/> Achieved maximum tolerated statin dose? <input type="checkbox"/> Repatha™ was prescribed by, or in consultation with, a cardiologist, an endocrinologist, and/or a physician who focuses on the management of cardiovascular disease and/or lipid disorders.		Has the patient failed on or do they have contraindications to any of the above therapies? _____ _____ Other pertinent medical history or drug therapy: _____ _____ _____ Family history of atherosclerotic cardiovascular disease (ASCVD): _____ _____ Allergies: _____ _____ _____	

INDICATIONS AND IMPORTANT SAFETY INFORMATION

Repatha™ is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (CVD), who require additional lowering of low density lipoprotein cholesterol (LDL-C).

Repatha™ is indicated as an adjunct to diet and other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) for the treatment of patients with homozygous familial hypercholesterolemia (HoFH) who require additional lowering of LDL-C.

The effect of Repatha™ on cardiovascular morbidity and mortality has not been determined.

The safety and effectiveness of Repatha™ have not been established in pediatric patients with HoFH who are younger than 13 years old.

The safety and effectiveness of Repatha™ have not been established in pediatric patients with primary hyperlipidemia or HeFH.

Contraindication: Repatha™ is contraindicated in patients with a history of a serious hypersensitivity reaction to Repatha™.

Allergic reactions: Hypersensitivity reactions (e.g. rash, urticaria) have been reported in patients treated with Repatha™, including some that led to discontinuation of therapy. If signs or symptoms of serious allergic reactions occur, discontinue treatment with Repatha™, treat according to the standard of care, and monitor until signs and symptoms resolve.

Adverse reactions: The most common adverse reactions (> 5% of Repatha™-treated patients and more common than placebo) were: nasopharyngitis, upper respiratory tract infection, influenza, back pain, and injection site reactions.

In a 52-week trial, adverse reactions led to discontinuation of treatment in 2.2% of Repatha™-treated patients and 1% of placebo-treated patients. The most common adverse reaction that led to Repatha™ treatment discontinuation and occurred at a rate greater than placebo was myalgia (0.3% versus 0% for Repatha™ and placebo, respectively).

Adverse reactions from a pool of the 52-week trial and seven 12-week trials:

Local injection site reactions occurred in 3.2% and 3.0% of Repatha™-treated and placebo-treated patients, respectively. The most common injection site reactions were erythema, pain, and bruising. The proportions of patients who discontinued treatment due to local injection site reactions in Repatha™-treated patients and placebo-treated patients were 0.1% and 0%, respectively.

Allergic reactions occurred in 5.1% and 4.7% of Repatha™-treated and placebo-treated patients, respectively. The most common allergic reactions were rash (1.0% versus 0.5% for Repatha™ and placebo, respectively), eczema (0.4% versus 0.2%), erythema (0.4% versus 0.2%), and urticaria (0.4% versus 0.1%).

Neurocognitive events were reported in less than or equal to 0.2% in Repatha™-treated and placebo-treated patients.

In a pool of placebo- and active-controlled trials, as well as open-label extension studies that followed them, a total of 1988 patients treated with Repatha™ had at least one LDL-C value < 25 mg/dL. Changes to background lipid-altering therapy were not made in response to low LDL-C values, and Repatha™ dosing was not modified or interrupted on this basis. Although adverse consequences of very low LDL-C were not identified in these trials, the long-term effects of very low levels of LDL-C induced by Repatha™ are unknown.

Musculoskeletal adverse reactions were reported in 14.3% of Repatha™-treated patients and 12.8% of placebo-treated patients. The most common adverse reactions that occurred at a rate greater than placebo were back pain (3.2% versus 2.9% for Repatha™ and placebo, respectively), arthralgia (2.3% versus 2.2%), and myalgia (2.0% versus 1.8%).

Homozygous familial hypercholesterolemia (HoFH): In 49 patients with HoFH studied in a 12-week, double-blind, randomized, placebo-controlled trial, 33 patients received 420 mg of Repatha™ subcutaneously once monthly. The adverse reactions that occurred in at least two (6.1%) Repatha™-treated patients, and more frequently than in placebo-treated patients, included upper respiratory tract infection (9.1% versus 6.3%), influenza (9.1% versus 0%), gastroenteritis (6.1% versus 0%), and nasopharyngitis (6.1% versus 0%).

Immunogenicity: Repatha™ is a human monoclonal antibody. As with all therapeutic proteins, there is a potential for immunogenicity with Repatha™.

Please see accompanying Full Prescribing Information.

*Required for processing.

†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 Repatha™. Other codes may be more appropriate given internal system guidelines, payor requirements, practice patterns, and the services rendered.

‡HeFH, heterozygous familial hypercholesterolemia; HoFH, homozygous familial hypercholesterolemia.

Fax Completed Form and/or Copy of Insurance Card(s), Front and Back, to the Specialty Pharmacy of your preference.

Please see page 4 for the RepathaReady™ Program Privacy Notice and Authorization, which must be signed by the patient or his or her legal guardian.

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Physician NPI #: _____

In order for your patient to be evaluated for eligibility for the Repatha™ Patient Start Program: **1)** All patient and provider signatures on this page must be completed. **2)** The prescription signature on page 1 must be completed.

Repatha™ Patient Start Program Patient and Prescriber Certification

Prescriber Certification and Information

With my signature below, I authorize my patient to receive one or more months of Repatha™ free of charge through the Repatha™ Patient Start Program after an initial coverage denial. I certify that all information provided on this form is accurate and truthful. I certify that this prescription is consistent with the labeled indications for Repatha™. I understand that Repatha™ provided in response to this request is not to be billed for, sold, purchased, or traded, to the best of my knowledge. I certify that my patient is new to Repatha™, meaning that he or she is not currently being treated with Repatha™ (except with a sample supply) and, to the best of my knowledge, has not previously been prescribed Repatha™.

Prescriber Signature (no stamps): **X** _____ Date: _____

Patient Certification

With my signature below, I certify that I understand that Repatha™ provided in response to this request is not to be billed, sold, purchased, or traded. I certify that my doctor has provided a prescription for continued therapy. I also certify that prior to this prescription, I have not been treated with Repatha™ (except with a sample supply), nor have I been prescribed Repatha™ previously by this or any other doctor.

Patient Signature: **X** _____ Date: _____

RepathaReady™ Program Privacy Notice and Authorization

I understand that once I sign this Authorization I am agreeing to be contacted by Amgen by mail, email, and/or phone for any of the purposes stated in this Authorization and that such communications may include the use of prerecorded voice messages and autodial systems.

My preferred method(s) of contact:

Email Phone Mail SMS/text (standard text message charges may apply from your wireless provider)

I choose to allow Amgen to leave me a voice message and/or send me an SMS/text that refers to the program by name and may contain personal health information about my condition or treatment.

My signature below certifies that I have **read, understand, and agree** to the Privacy Notice and Patient Authorization to release my personal health information as described in full detail on the next page.

Patient Name: _____

Name of Legal Guardian (if needed): _____

Patient Signature (or Legal Guardian): **X** _____ Date: _____

The Repatha™ Patient Start Program is not available in Massachusetts, Puerto Rico, or where prohibited by law.

 **Repatha™**
(evolocumab) injection
140 mg/mL

Amgen and its contractors will not sell any of your Personal Health Information and will only use it for the purposes described in the Privacy Notice and Authorization.

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Physician NPI #: _____

RepathaReady™ Program Privacy Notice and Authorization

Continued from previous page

I authorize Amgen and its contractors (“Amgen”) to use and/or disclose *my personal information* including my personal health information for the following purposes:

- To enroll me in and/or continue my participation in Amgen’s **RepathaReady™** patient support program and/or any other Amgen-affiliated patient support services and related activities. For example, the option to join the Repatha™ (evolocumab) Sharps Mail-Back Program to receive sharps disposal containers, the Repatha™ Copay Card program if eligible, the Repatha™ Patient Start Program, reimbursement assistance programs, drug coverage verification, nurse educator services, and disease management support;
- To contact, upon my permission, my healthcare team (including my doctor and his team) and share with them some of my important health information;
- **To provide me with information and marketing materials relating to Amgen products and services, and/or my condition or treatment;** and/or
- To improve, develop, evaluate, and continue products, services, materials, and programs related to my condition or treatment.

I also authorize any healthcare providers, healthcare plans, pharmacies, pharmaceutical companies, laboratories, and/or their contractors (“Healthcare Providers”) to disclose any of *my personal health information* to Amgen as requested by Amgen and as necessary for the purposes stated in this Authorization. I understand that certain Healthcare Providers may receive remuneration from Amgen in exchange for my personal health information and/or for any patient support services and promotional communications provided to me.

I understand that my personal health information includes any information, in electronic or physical form, in the possession of or derived from a healthcare provider, healthcare plan, pharmacy, pharmaceutical company, and/or contractor regarding: (1) my medical history, including my entire medical file and complete patient history; (2) my healthcare plans benefits; (3) limits or restrictions on payments covered by my healthcare plan policy; and/or (4) my health or my adherence to treatment.

Expiration, Right to Obtain a Copy, and Right to Cancel

I understand that Amgen may use my personal information, including my personal health information, for 10 years once I accept this Authorization or for a shorter time period if required by state law. I also understand that I can cancel this Authorization at any time by calling Amgen at 1-844-REPATHA or by sending my request for cancellation by mail to PO Box 220326 Charlotte, NC 28222. Once Amgen receives and processes my cancellation, it will not use my personal information going forward; however, I understand that canceling my Authorization will not affect the use of my personal information that occurred before my request was processed. I further understand that if a Healthcare Provider is disclosing my personal health information to Amgen on an ongoing basis as authorized herein, my cancellation with Amgen will only be effective with respect to any such Healthcare Providers once they actually receive notice of my cancellation from Amgen.

No Effect on Treatment

I understand that I do not have to agree to the uses and disclosures of my personal information contained in this Notice and Authorization. I understand that Amgen, as well as Healthcare Providers, cannot require me, as a condition of receiving medications, prescription drugs, treatment, or other care, to agree to this Authorization. However, I also understand that Amgen cannot provide me with any of the **RepathaReady™** program services without my authorization, including but not limited to my enrollment or continued participation in patient support services. Under these circumstances, I may be responsible for the full costs of my treatment.

Information Received From Healthcare Providers

I understand that when a Healthcare Provider discloses my personal health information to Amgen for the purposes contained in this Notice and Authorization, the personal health information disclosed may not be covered by any federal law relating to the use of my personal health information or how it is disclosed. There is no guarantee that my personal health information received by Amgen from a Healthcare Provider might not be released to a third party. I further understand that if a Healthcare Provider is disclosing my personal health information on an ongoing basis to Amgen, this Authorization only permits Healthcare Providers to do so for one year once I accept this Authorization or for a shorter time period if required by state law.

AMGEN®