aimovig (erenumab-aooe) injection 70 mg/mL

SERVICE REQUEST FORM AND PRESCRIPTIONS

ATTN Prescriber: Please attach a separate prescription or utilize eRx if this section does not comply with your state prescription laws.

ALL FIELDS REQUIRED, UNLESS NOTED.

Fax: 833-873-1499
Phone: 833-AIMOVIG (833-246-6844)
Monday - Friday, 8 am - 8 pm ET

aimovig ally

Our Service Request Form is the only form you'll need to get started with Aimovig Ally™

To save time you can submit this form electronically at www.iassist.com, or you can fax pages 1 and 2 to 833-873-1499.

1 Patient Information

Patient's Name (first, MI, last)

Sex: ❑ Male ❑ Female

Date of Birth (mm/dd/yyyy)

Cell Phone

Home Phone

Street Address

City

State

Zip Code

E-mail

OK to leave detailed message about Aimovig™ (erenumab-aooe) on: ☑ Cell Phone ❑ Home Phone

2 Prescription Insurance Information

If you do not have insurance, please see the optional Amgen Safety Net Foundation Application in section 3 below. *(Please include a copy of your insurance card(s) [front and back] to determine your coverage for Aimovig™.)*

Beneficiary/Cardholder Name

ID #

Prescription Insurance/Primary Insurance

Phone #

Rx Group #

Rx BIN #

Rx PCN #

Secondary Insurance

ID #

Rx Group #

Rx BIN #

Rx PCN #

☑ Please send me a sharps disposal container

❑ **I would like to be contacted to enroll in the Aimovig™ Copay Program (for commercially insured patients only)**

STOP

Signature is required for enrollment in services

Patient Authorization

I certify that I have read and agree to the attached Patient Authorization on pages 4 and 5.

STOP

✗

Patient's (or Personal Representative's) Signature Date (mm/dd/yyyy) **Print Patient's (or Personal Representative's) Name**

☑ **I also certify that I have read and agree to receive text messages and calls as explained in the Telephone Consumer Protection Act (TCPA) consent on page 5. (optional)**

3 Optional Amgen Safety Net Foundation

You may be able to receive Aimovig™ at no cost from Amgen Safety Net Foundation if you meet the following eligibility requirements:

- Resident of the United States or its territories
- Those in one of the following insurance situations:
  - Uninsured
  - Patient's Insurance Plan excludes the Amgen product
- Patient demonstrates a financial need: Income at or below 500% of the federal poverty limit (FPL)
- Certain standard Medicare Part D patients with product coverage that cannot afford their out-of-pocket costs may be eligible. These patients must:
  - Meet additional financial criteria demonstrating their inability to afford the product
  - Not be eligible for Medicaid or Medicare's low-income subsidy (LIS)
  - Satisfy all payer guidelines and prior authorization (PA) requirements prior to applying for assistance
  - Not have any other financial support options

To apply for support, answer the following questions:

❑ Yes ❑ No **1.** I have lived in the United States, American Samoa, Guam, Puerto Rico, or the U.S. Virgin Islands for 6 months or longer.

❑ Yes ❑ No **2.** I have lived in my current state for 6 months or longer.

3. My household makes $_____ Yearly (Include the gross income of all individuals in your household. Gross income includes all Social Security, Social Security disability income [SSDI], unemployment, pensions, and any other income. You may be asked to provide proof of income).

4. How many individuals live in your household, including yourself? _____ (Your household size includes all individuals you reported on your most recent U.S. Tax Return. If you did not file a Tax Return, please include all individuals that live with you (e.g., you, your children, your spouse, your parents, and other family).

❑ Yes ❑ No **5.** I am either a U.S. citizen, or a resident alien who has resided in the U.S. for 5 years or longer.

❑ Yes ❑ No **6.** I am Uninsured.

❑ Yes ❑ No **7.** My insurance plan excludes Aimovig™.

❑ Yes ❑ No **8.** I am a Medicare Part D patient that cannot afford my cost share.
- If yes, have you been denied Medicare's LIS (Extra Help)? ❑ Yes ❑ No

❑ Yes ❑ No **9.** Do you have Medicaid? If yes, is it Emergency Medicaid? ❑ Yes ❑ No

❑ Yes ❑ No **10.** Have you been denied Medicaid? (You may be asked to provide proof of Medicaid denial.)

STOP

Signature is only required if you are applying for the optional Amgen Safety Net Foundation

Patient Signature for Amgen Safety Net Foundation

I certify that I have read and agree to the Amgen Safety Net Patient Authorization and Certification on pages 5 and 6.

Amgen Safety Net Foundation does not charge a fee for participation. If you use a third-party who charges a fee for help with your enrollment or refills of your medicine(s), this money is not paid to Amgen Safety Net Foundation.

STOP

✗

Patient's (or Personal Representative's) Signature Date (mm/dd/yyyy) **Print Patient's (or Personal Representative's) Name**

Please see Indication and Important Safety Information on page 3.