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

STOP

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.

✗

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.

aimovig (erenumab-aooe) injection 70 mg/mL

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Monday - Friday, 8 am - 8 pm ET

aimovig ally

Patient's Name: _____ Date of Birth: _____

4 Prescriber Information

Prescriber's Name

NPI # Tax ID #

Practice Name

Office Contact Name

Street Address

Phone (and ext) Fax

City State Zip Code

Primary diagnosis ICD-10: _____

❑ Request for in-home supplemental injection training (Prescriber confirms that in-office training will be provided.)

E-mail

5 Pharmacy Prescription

Aimovig™ (erenumab-aooe) 70 mg/mL SureClick®: ❑ Inject 70 mg OR ❑ Inject 140 mg Frequency: Subcutaneous once monthly

Preferred Pharmacy: _____

Dispense: ❑ One 70 mg/mL SureClick® ❑ Two 70 mg/mL SureClick® ❑ Dispense as written Refills: _____

STOP

Prescriber Certification

STOP

I certify that the above therapy is medically necessary and that the information provided is accurate, to the best of my knowledge. I certify that I am the prescriber who has prescribed Aimovig™ to the previously identified patient and that I provided the patient with a description of Aimovig Ally™.

✗ _____

Prescriber's Signature (No stamps please) Date (mm/dd/yyyy)

For the purposes of transmitting these prescriptions, I authorize Novartis Pharmaceuticals Corporation and Amgen and their affiliates, business partners, and agents to forward as my agent for these limited purposes these prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies designated by the patient and/or preferred by the patient's benefit plan.

6 Optional Aimovig™ Free Trial Offer Rx

❑ Free trial only (no reimbursement services requested at this time)

Free trial is optional and available at no cost to patients new to Aimovig™. Patients are eligible to receive two doses of Aimovig™ dispensed directly from the Aimovig Ally™ Pharmacy. Doses are delivered on a monthly basis and will be coordinated with the patient. If the dose changes, please contact the Program. No purchase required. Patient may only redeem this offer once. This free trial is not health insurance and is not contingent on or a guarantee of insurance coverage. Trial product cannot be submitted for reimbursement under any healthcare program. Limitations may apply. Not available to residents of Massachusetts. Novartis Pharmaceuticals Corporation and Amgen reserve the right to rescind, revoke, or amend this offer without notice. Enrollment must occur by 12/31/2018.

Aimovig™ (erenumab-aooe) 70 mg/mL SureClick®: ❑ Inject 70 mg OR ❑ Inject 140 mg Frequency: Subcutaneous once monthly

Dispense: ❑ One 70 mg/mL SureClick® ❑ Two 70 mg/mL SureClick® ❑ Dispense as written Refills: 1

Ship 1st dose to: ❑ Patient OR ❑ HCP office (if selected patient accepts this may require an additional visit to the office to receive the medication)

Note: The 2nd dose will be shipped directly to the patient.

7 Optional Aimovig™ Bridge to Commercial Coverage Rx

Eligible patients must have commercial insurance, a valid prescription for Aimovig™, previously failed another preventive migraine treatment, and either received a denial from a prior authorization for Aimovig™ or participate in an insurance plan that does not provide coverage for Aimovig™. Program provides up to 12 doses for free to patients while insurance coverage is pursued. Once insurance approval is obtained, patient is no longer eligible for the Program. By recommending enrollment in this Program, Prescriber acknowledges that they intend to pursue commercial coverage of Aimovig™ for their patient. Program requires the submission of an appeal of the prior authorization within 90 days of enrollment and if denied, a second appeal within 120 days. For patients who participate in an insurance plan that does not provide coverage for Aimovig™, Program requires the submission of a medical exception request or equivalent within 6 months of enrollment. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Program product cannot be submitted for reimbursement under any healthcare program. Program is not available to patients whose medications are reimbursed in whole or in part by Medicare, Medicaid, TRICARE, or any other federal or state program. Patients may be asked to reverify insurance coverage status during the course of the Program. Limitations may apply. Not available to residents of Massachusetts. Novartis Pharmaceuticals Corporation and Amgen reserve the right to rescind, revoke, or amend this Program without notice. Enrollment must occur by 12/31/2018.

Aimovig™ (erenumab-aooe) 70 mg/mL SureClick®: ❑ Inject 70 mg OR ❑ Inject 140 mg Frequency: Subcutaneous once monthly

Dispense: ❑ One 70 mg/mL SureClick® ❑ Two 70 mg/mL SureClick® ❑ Dispense as written Refills: 5

STOP

Prescriber Certification

STOP

I understand that any Aimovig™ provided at no charge to the patient under the Free Trial Offer and/or Bridge to Commercial Coverage program is provided on a complimentary basis. I will not submit or cause to be submitted any claims for reimbursement for such product to any third-party payer, including a federal healthcare program, nor will I return any free product for credit. I understand the product is intended solely for the patient for whom it has been prescribed; I will not sell or attempt to sell or otherwise transfer the free product for economic value or another's use. In connection with the Free Trial Offer, I certify that the patient is new to Aimovig™, meaning that he or she is not currently being treated with Aimovig™ and, to the best of my knowledge, has not previously been prescribed Aimovig™.

I certify that the above therapy is medically necessary and that the information provided is accurate, to the best of my knowledge. I certify that I am the prescriber who has prescribed Aimovig™ to the previously identified patient and that I provided the patient with a description of Aimovig Ally™.

✗ _____

Prescriber's Signature (No stamps please) Date (mm/dd/yyyy)

Please see Indication and Important Safety Information on page 3.

INDICATION

Aimovig™ (erenumab-aooe) is indicated for the preventive treatment of migraine in adults.

IMPORTANT SAFETY INFORMATION

- The most common adverse reactions in clinical studies (≥ 3% of Aimovig™-treated patients and more often than placebo) were injection site reactions and constipation.

PLEASE READ THE FOLLOWING CAREFULLY, THEN SIGN AND DATE WHERE INDICATED ON PAGE 1

PATIENT AUTHORIZATION

I give permission for my healthcare providers (HCPs), pharmacies, health insurer(s), third-party contractors, and service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("personal information") to Novartis Pharmaceuticals Corporation and Amgen Inc., its affiliates, business partners, and agents ("Novartis and Amgen") so that Novartis and Amgen can:

(i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with Aimovig™ (erenumab-aooe),

(ii) coordinate my receipt of and payment for Aimovig™,

(iii) facilitate my access to Aimovig™,

(iv) provide me with information about Novartis and Amgen products, disease education and management programs and promotional materials,

(v) manage Aimovig Ally™ and affiliated programs (including the Aimovig™ Copay Program if I am eligible),

(vi) provide me with medication reminders and support, and

(vii) conduct quality assurance, surveys, and other internal business activities in connection with Aimovig Ally™

I give permission to Novartis and Amgen to disclose my personal information to my HCPs, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and HCPs may receive remuneration (payment) from Novartis and Amgen in exchange for disclosing my personal information to Novartis and Amgen and/or for providing me with therapy support services.

I understand that once my personal information is disclosed, it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (cancel) or get a copy of this authorization at any time by calling Aimovig Ally™ at 1-833-246-6844 or writing to PO Box 2953, Phoenix, AZ 85062-2953. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a HCP is disclosing my personal information to Novartis and Amgen on an authorized, ongoing basis, my cancellation with Novartis and Amgen will be effective with respect to any such HCPs as soon as they receive notice of my cancellation.

My refusal or future revocation will not affect my medical treatment or insurance benefits; however, if I revoke this authorization, I may no longer be able to participate in Aimovig Ally™. If I revoke this authorization, Novartis and Amgen will stop using or sharing my information (except as necessary to end my participation in the program), but my revocation will not affect uses and disclosures of personal information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier. I also understand that Aimovig Ally™ may change or end at any time without prior notification.

Please see Indication and Important Safety Information on page 3.

PLEASE READ THE FOLLOWING CAREFULLY, THEN SIGN AND DATE WHERE INDICATED ON PAGE 1

PATIENT AUTHORIZATION (continued)

I consent to Novartis and Amgen calling and texting me at the phone number(s) I have provided with promotional communications relating to Novartis and Amgen products and services and/or my condition or treatment. Novartis and Amgen may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or SMS/text message (standard text messaging rates may apply).

I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided, and I agree to notify Novartis and Amgen promptly if any of my number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that Novartis and Amgen do not permit my personal information to be used by its business partners for their own separate marketing purposes. I understand and agree that personal information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

Telephone Consumer Protection Act (TCPA) Consent. I also understand that by checking the box and signing on page 1, I consent to receive marketing calls and texts from and on behalf of Novartis and Amgen, made with an autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Number of messages will vary based on your program selections. Message and data rates may apply. Text STOP to opt out and HELP for help.

FOR AMGEN SAFETY NET FOUNDATION, PLEASE READ THE FOLLOWING CAREFULLY, THEN SIGN AND DATE WHERE INDICATED ON PAGE 1

PATIENT CERTIFICATION AND AUTHORIZATION TO DISCLOSE INFORMATION SECTION

Amgen Safety Net Foundation, "the Foundation," is a nonprofit patient assistance program supported by Amgen that provides qualifying patients with Amgen products at no cost.

Authorization to Disclose Information

I authorize the Foundation, Amgen, their agents, and third-party contractors or their service providers authorized to administer the Foundation to:

- use the information that I provided on this form to evaluate my eligibility for and assist with my continued participation in the Foundation.
- obtain my consumer report from a consumer reporting agency to be used with the eligibility determination process.
- contact me to seek feedback on the Foundation's services.

For these purposes, I also authorize my physician, other HCPs, pharmacies, health plan(s), caregivers, and family members to disclose to the Foundation, Amgen, their agents, and third-party contractors or their service providers authorized to administer the Foundation information about my medical condition, treatment, and health insurance coverage.

FOR AMGEN SAFETY NET FOUNDATION, PLEASE READ THE FOLLOWING CAREFULLY, THEN SIGN AND DATE WHERE INDICATED ON PAGE 1

PATIENT CERTIFICATION AND AUTHORIZATION TO DISCLOSE INFORMATION SECTION (continued)

I understand that:

- I may refuse to sign this form, but if I refuse to sign or revoke my authorization, I will not be able to receive assistance from the Foundation.
- my HCP or insurers will not condition my medical treatment or insurance benefits on my agreement to sign this form.
- once I provide the information (as described above) to the Foundation, Amgen, the agents, and third-party contractors or their service providers working on their behalf pursuant to this authorization, federal privacy laws may not prevent further disclosure of this information.
- I may receive a copy of this form at any time by contacting the Foundation at 1-888-762-6436, and I may revoke it by mailing a revocation to PO Box 18769, Louisville, KY 40261-7821.
- a revocation must be in writing and is not effective to the extent that action has already been taken based on this authorization.
- this authorization will expire 1 year after the date it is signed below or 1 year after the last date I receive product from the Foundation, whichever is later.

AMGEN SAFETY NET FOUNDATION PATIENT CERTIFICATION

I certify that:

- the information I provided on this form is complete and accurate.
- I will not request reimbursement from any insurance carrier or government health benefit program for Amgen products that I receive from the Foundation.
- I will notify the Foundation within 30 days if my financial status or health insurance coverage changes.
- if I decide to enroll in a Medicare Part D plan, I will inform the Foundation at the number above prior to enrolling. If I receive notice that I have “auto-enrolled” in a Medicare Part D plan, I will immediately inform the Foundation.
- I will not sell, trade, or distribute Amgen products given to me by the Foundation.

I understand that completing this form is not a guarantee of eligibility for the Foundation. I also understand that the Foundation may change or discontinue the program at any time without notice, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year.

I understand that if I am currently enrolled in a Medicare Part D plan, I cannot use my Part D plan benefits for products received through Amgen Safety Net Foundation for the duration of my enrollment in the Foundation. Any medication I receive through Amgen Safety Net Foundation will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D. Amgen Safety Net Foundation will send a letter to my Medicare Part D plan notifying them of the assistance I am receiving.

AMGEN® NOVARTIS

Please see Indication and Important Safety Information on page 3.