

**FACILITY APPLICATION FORM**

**Instructions:** This form should be completed by a facility contact to begin the facility enrollment process into The Safety Net Foundation. A facility must enroll in The Safety Net Foundation in order to participate in the product replacement program. This form only needs to be submitted once per facility.

**Facility Mailing Information** *(address where you would like written communication mailed)*

Facility Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please indicate the facility type:

- |                                |                                     |                         |
|--------------------------------|-------------------------------------|-------------------------|
| _____ Community Pharmacy       | _____ Free Standing Dialysis Center | _____ Hospital          |
| _____ Hospital Dialysis Center | _____ Hospital Pharmacy             | _____ Infusion Facility |
| _____ Provider's Office        | _____ Specialty Pharmacy            |                         |

Facility HIN #: \_\_\_\_\_ DEA #: \_\_\_\_\_ AHA #: \_\_\_\_\_ NPI #: \_\_\_\_\_

**Note: The Safety Net Foundation cannot provide assistance for inpatient hospital use.**

**Facility Mailing Contact Information**

Contact First Name: \_\_\_\_\_ Contact Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Facility's Preferred Method of Written Communication (primary) – check only one:     Email     Fax     Mail

Facility's Preferred Method of Written Communication (secondary) – check only one:     Email     Fax     Mail

**Facility Shipping Information** *(address where you would like product shipped)*

Check here if shipping address information is the same as the mailing information

Facility Name: \_\_\_\_\_

Address 1: \_\_\_\_\_  
*(PO BOX is not accepted)*

Address 2: \_\_\_\_\_  
*(PO BOX is not accepted)*

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Facility Shipping Contact Information**

Check here if shipping contact information is the same as the mailing information

Shipping Contact First Name: \_\_\_\_\_ Shipping Contact Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Visit us at [www.safetynetfoundation.com](http://www.safetynetfoundation.com) to access program information, forms, and submit online requests.**

Facility Name: \_\_\_\_\_

### Third Party Administrator Information

If your facility uses a third party administrator (TPA) to facilitate processing for patient assistance programs, please complete the information below:

Send communications to TPA in addition to Facility

Company Name: \_\_\_\_\_

Contact First Name: \_\_\_\_\_ Contact Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email Address: \_\_\_\_\_

TPA's Preferred Method of Written Communication (primary) – check only one:     Email     Fax     Mail

TPA's Preferred Method of Written Communication (secondary) – check only one:     Email     Fax     Mail

### Pharmacy Director Information

If your facility has a Pharmacy Director, please list his/her name (required for facilities that use Third Party Administrators):

Pharmacy Director First Name: \_\_\_\_\_ Pharmacy Director Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Pharmacy Director's Preferred Method of Written Communication (primary) – check only one:     Email     Fax     Mail

Pharmacy Director's Preferred Method of Written Communication (secondary) – check only one:     Email     Fax     Mail

#### For Internal Use Only

The Safety Net Foundation Customer Number: \_\_\_\_\_

Visit us at [www.safetynetfoundation.com](http://www.safetynetfoundation.com) to access program information, forms, and submit online requests.

**FACILITY CERTIFICATION FORM**

Facility Name: \_\_\_\_\_

By submitting this application, I agree to the following:

- I will provide Amgen products for patients in a medically appropriate manner based on a valid physician's order or prescription.
- I understand that The Safety Net Foundation reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen products under this program to any patient or facility.
- I understand that product is provided on a replacement basis. Participating providers are required to stock the product and apply for replacement product through The Safety Net Foundation.
- I understand that an insurance verification may be required to determine a patient's eligibility for The Safety Net Foundation.
- I understand that the product received through The Safety Net Foundation is for medically needy patients living in the United States and its territories.
- I certify that I will not charge or cause any other party to charge any third party or patient for Amgen products for which replacement is sought under The Safety Net Foundation. I further certify that all product received in connection with The Safety Net Foundation will replace such product; be furnished free of charge for treatment of needy patients who meet The Safety Net Foundation criteria; and, that no part of any charges for Amgen products replaced under The Safety Net Foundation will be claimed as bad debt.
- I understand that The Safety Net Foundation is available for outpatient use only. I certify that no replacement will be requested for product administered in the hospital inpatient setting.
- I represent that the information contained in all patient applications under my facility, including the patient application form will be complete and accurate to the best of my knowledge. This representation does not require my independent investigation of the information. If I become aware of any changes in the patient's circumstances that affect The Safety Net Foundation eligibility, I agree to notify The Safety Net Foundation immediately.
- I agree to release or make available to an authorized The Safety Net Foundation representative the medical and financial records for The Safety Net Foundation patients who have provided consent for such disclosure for the sole purpose of verifying patients' eligibility for The Safety Net Foundation. I agree that I will not provide patient information without obtaining appropriate consent from each patient prior to releasing or making available to The Safety Net Foundation such records or information.
- I further certify that I am authorized to act for the institution for which I am signing.

Signature of Facility's Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Send completed forms to:

**The Safety Net Foundation**  
**PO BOX 13185**  
**La Jolla, CA 92039-3185**  
**Phone: 888/SN-AMGEN (888/762-6436) Fax: 866/549-7239**

Visit us at [www.safetynetfoundation.com](http://www.safetynetfoundation.com) to access program information, forms, and submit online requests.