## **PATIENT REQUEST FORM**





Complete this form to request outreach to patients to begin their enrollment for Amgen SupportPlus services. Fax the completed Form to Amgen SupportPlus at 1-833-626-5384. Let your patient know to expect a call from Amgen SupportPlus to help them enroll into the program.

**PLEASE NOTE:** Amgen is committed to respecting the privacy of patients. Clinical notes and additional documents are **NOT required** for us to provide the services requested below. Please **DO NOT** provide anything beyond the information requested on the Patient Request Form. Review of clinical documentation sent to Amgen SupportPlus could delay our response time back to your office.

Medication(s)					
*Select only one medication  ENBREL® (etanercept) Please see the ENBREL® full <u>Prescr</u> Information, including <u>Medicatio</u>	<u>ibing</u> Please see	Please see the Otezla® full <u>Prescribing Information</u> . Please		VITA™ (adalimumab-atto) e see the AMJEVITA™ full <u>Prescribing</u> nation, including <u>Medication Guide</u> .	
Mandatory Prescriber Information					
First Name		Last Name			
NPI Number (required)	Facility Name				
Address 1	,				
Address 2		- City	 State	ZIP	
		,			
Phone Number	Fax Number	Office Contact Name			
Mandatory Patient Information					
First Name		Middle Initial Last Name			
Date of Birth (MM/DD/YYYY)	Sex at Birth	n: Male Female Prefe	er not to say		
Address 1					
Address 2		City	State	ZIP	
Home Phone Number <sup>†</sup>	Mobile Phone Number <sup>†</sup>	Email Address			
*0		and the desired state of the st			

\*By completing and faxing this form, 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.

†By providing a phone number, you represent that your patient is aware of the disclosure and has given permission to be contacted by Amgen.