Sensipar®
(cinacalcet) Tablets
30mg·60mg·90mg

AMGEN ASSIST®
SIMPLIFYING REIMBURSEMENT

**1-800-272-9376 (telephone)**
**1-888-508-8090 (fax)**

# Insurance Verification Request Form for Sensipar®

## PRESCRIBER/FACILITY CONTACT INFORMATION

Contact/Requestor Name _____ Phone Number (_____) _____ - _____
Facility Name _____ Fax Number (_____) _____ - _____
Treating Prescriber's Name _____ State License Number _____
Address _____ Tax ID Number _____
City, State, ZIP Code _____ NPI Number _____
Physician Specialty _____ PTAN Number _____
Contact Type/Title: ☐ Physician ☐ Nurse ☐ Office Practice Manager/Billing Office Staff ☐ Social Worker ☐ Dietician
☐ Patient ☐ Caregiver ☐ Other _____

Prescriber/Facility Contact Information

## REQUESTOR PREFERENCES

Primary contact for relaying results: ☐ Provider Contact/Requestor ☐ Physician
How would you prefer results relayed? ☐ Phone ☐ Fax ☐ No Preference
Please check all fulfillment channels that you would like researched:
☐ Buy and Bill ☐ Retail Pharmacy ☐ Specialty Pharmacy ☐ Mail Order Pharmacy

Requestor Preferences

## PATIENT GENERAL INFORMATION

First and Last Name _____ Gender: ☐ Male ☐ Female
Address _____ Date of Birth _____ / _____ / _____ (MM/DD/YY)
City, State, ZIP Code _____ Phone Number (_____) _____ - _____

Patient General Information

## PATIENT MEDICAL AND TREATMENT INFORMATION

Is this patient on dialysis? ☐ Yes N18.6 (End-stage renal disease) ☐ No
**Relevant Diagnosis (ICD-10 code):** ☐ N25.81 (Secondary hyperparathyroidism of renal origin) ☐ E21.0 (Primary hyperparathyroidism)
☐ Z99.2 (Dependence on renal dialysis) ☐ Other (Specify ICD-10 code) _____
Is the patient currently taking Sensipar®? ☐ Yes ☐ No Dosage: ☐ 30 mg ☐ 60 mg ☐ 90 mg ☐ Other (Specify Dosage) _____
Has the patient taken Sensipar® in the past? ☐ Yes ☐ No

Patient Medical And Treatment Information

## PRIMARY PAYER (Please fax a copy of the front AND back of the insurance card and pharmacy benefit card.)

**MEDICAL BENEFIT**
Payer Name _____
Payer Phone Number (_____) _____ - _____
Member ID Number _____
Group Number _____
Plan Type (eg, HMO, PPO) _____

**PHARMACY BENEFIT**
Payer Name _____
Payer Phone Number (_____) _____ - _____
Member ID Number _____
Group Number _____
BIN Number _____ PCN Number _____

Primary Payer

## SECONDARY PAYER (Please fax a copy of the front AND back of the insurance card and pharmacy benefit card.)

**MEDICAL BENEFIT**
Payer Name _____
Payer Phone Number (_____) _____ - _____
Member ID Number _____
Group Number _____
Plan Type (eg, HMO, PPO) _____

**PHARMACY BENEFIT**
Payer Name _____
Payer Phone Number (_____) _____ - _____
Member ID Number _____
Group Number _____
BIN Number _____ PCN Number _____

Secondary Payer

By completing and providing Amgen Assist® with this form, you represent that your patient is aware of the disclosure of their personal health information to Amgen and its agents for Amgen 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.

**Fax Completed Form and/or Copy of Insurance Card(s) to Amgen Assist®: 1-888-508-8090**

*This verification of benefits is not a guarantee of payment by the payer, but is deemed as current coverage information as relayed by the payer to the Amgen Assist® hotline.*

***Please see Indications and Important Safety Information on the next page.***

## Indications

Sensipar® (cinacalcet) is indicated for the treatment of secondary hyperparathyroidism (HPT) in adult patients with chronic kidney disease (CKD) on dialysis.

Limitations of Use:

Sensipar® is not indicated for use in patients with CKD who are not on dialysis because of an increased risk of hypocalcemia.

Sensipar® (cinacalcet) is indicated for the treatment of hypercalcemia in adult patients with primary hyperparathyroidism (HPT) for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy.

Sensipar® (cinacalcet) is indicated for the treatment of hypercalcemia in adult patients with parathyroid carcinoma.

## Important Safety Information

**Contraindication:** Sensipar® (cinacalcet) treatment initiation is contraindicated if serum calcium is less than the lower limit of the normal range (8.4 mg/dL).

**Hypocalcemia:** Sensipar® lowers serum calcium and can lead to hypocalcemia. Life threatening events and fatal outcomes associated with hypocalcemia have been reported in patients treated with Sensipar®, including pediatric patients. The safety and effectiveness of Sensipar® have not been established in pediatric patients.

Decreases in serum calcium can prolong the QT interval, potentially resulting in ventricular arrhythmia. Cases of QT prolongation and ventricular arrhythmia have been reported in patients treated with Sensipar®. Patients with conditions that predispose to QT interval prolongation and ventricular arrhythmia may be at increased risk for QT interval prolongation and ventricular arrhythmias if they develop hypocalcemia due to Sensipar®. Closely monitor corrected serum calcium and QT interval in patients at risk receiving Sensipar®.

Significant reductions in calcium may lower the threshold for seizures. Monitor serum calcium levels in patients with seizure disorders on Sensipar®.

Concurrent administration of Sensipar® with calcium-lowering drugs including other calcimimetics could result in severe hypocalcemia. Parsabiv™ (etelcalcetide) and Sensipar® should not be given together. Closely monitor serum calcium in patients receiving Sensipar® and concomitant therapies known to lower serum calcium levels.

Patients with secondary HPT: Serum calcium and serum phosphorus should be measured within 1 week and PTH should be measured 1 to 4 weeks after initiation or dose adjustment of Sensipar®. Once the maintenance dose has been established, serum calcium and serum phosphorus should be measured approximately monthly, and PTH every 1 to 3 months.

Patients with primary HPT or parathyroid carcinoma: Serum calcium should be measured within 1 week after initiation or dose adjustment of Sensipar®. Once maintenance dose levels have been established, serum calcium should be measured every 2 months.

**Upper Gastrointestinal Bleeding:** Cases of gastrointestinal (GI) bleeding, mostly upper GI bleeding, have occurred in patients using calcimimetics, including Sensipar®, from postmarketing and clinical trial sources. The exact cause of GI bleeding in these patients is unknown.

Patients with risk factors for upper GI bleeding, such as known gastritis, esophagitis, ulcers or severe vomiting, may be at increased risk for GI bleeding with Sensipar®. Monitor patients for worsening of common Sensipar® GI adverse reactions and for signs and symptoms of GI bleeding and ulcerations during Sensipar® therapy.

**Hypotension, Worsening Heart Failure and/or Arrhythmias:** In Sensipar® postmarketing use, isolated, idiosyncratic cases of hypotension, worsening heart failure, and/or arrhythmia were reported in patients with impaired cardiac function. The causal relationship to Sensipar® therapy could not be completely excluded and may be mediated by reductions in serum calcium levels.

**Adynamic Bone:** Adynamic bone disease may develop if intact parathyroid hormone (iPTH) levels are suppressed below 100 pg/mL.

**Adverse Reactions:** In clinical trials of patients with secondary HPT comparing Sensipar® to placebo, the most commonly reported side effects were nausea (31% vs. 19%), vomiting (27% vs. 15%), and diarrhea (21% vs. 20%).

In clinical trials of patients with primary HPT and parathyroid carcinoma treated with Sensipar®, the most commonly reported side effects were nausea (63%), vomiting (46%), and paresthesia (20%).

**Please click here to see the Sensipar® full Prescribing Information.**

## OPTIONAL SENSIPAR® PHARMACY CARD PROGRAM DIRECT ENROLLMENT
## Confirm Your Eligibility

Sensipar®
(cinacalcet) Tablets
30mg · 60mg · 90mg

| | |
|---|---|
| Are you (or the patient) a resident of one of the 50 United States or Puerto Rico? | ❑ Yes ❑ No |
| Do you have commercial or private healthcare insurance? | ❑ Yes ❑ No |
| Is your Sensipar® prescription paid for in whole or in part by any<br>• Federal government funded healthcare program, such as Medicare Part B and/or Part D, Medicare Advantage, Medicaid, Medigap, Veterans Affairs (VA), the Department of Defense (DoD) or TRICARE®<br>**OR**<br>• Any similar state funded program such as a state pharmacy assistance program? | ❑ Yes ❑ No |

| | |
|---|---|
| The Sensipar® Pharmacy Card is ONLY valid for patients with commercial or private insurance whose Sensipar® is NOT paid for, in whole or in part, by any federal, state or government-funded healthcare program. If at any time you begin receiving Sensipar® prescription drug coverage under any such federal, state or government-funded healthcare program, you will no longer be eligible to participate in the Sensipar® Pharmacy Card Program and you may no longer use this card. Do you agree with this statement? | ❑ Yes ❑ No |
| Are you enrolled in a health plan purchased through the federal Health Insurance Marketplace at healthcare.gov, or a StateExchange such as Covered California or the NY State of Health, with health insurance coverage after January 1, 2014? | ❑ Yes ❑ No |

Eligibility Criteria:
Open to patients with a Sensipar® prescription and commercial insurance for Sensipar®. Patients may not seek reimbursement for value received from the Sensipar® Pharmacy Card program from any third-party payers, including a flexible spending account or healthcare savings account. This program is not open to uninsured patients or patients receiving prescription reimbursement under any federal, state or government-funded healthcare program, such as Medicare, Medicare Advantage, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), the Department of Defense (DoD) or TRICARE® or where prohibited by law. If at any time patients begin receiving prescription drug coverage under any such federal, state or government-funded healthcare program, patients will no longer be able to use this card and must call the Sensipar® Pharmacy Card Program at 1-877-334-8684 (Monday through Friday, 8:00 am to 8:00 pm ET) to stop participation. Restrictions may apply. Offer subject to change or discontinuation without notice. **This is not health insurance**.

## Privacy Notice and Authorization

In accordance with my signature below, I understand and consent to Amgen contacting me using the contact information provided in this form to enroll me in, operate, and administer Amgen patient support services and/or Sensipar® Pharmacy Card Program as described in the Patient Privacy Authorization other than promotional communications by telephone or SMS/text (to which I can separately opt-in below). I understand that the operation and administration of this program may require that Amgen contact me by telephone or SMS/text.

**My preferred method(s) of contact:**

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

❑ In addition to the above consent, I understand that by checking this box and signing below, I consent to Amgen calling and texting me at the phone number(s) I have provided with promotional communications relating to Amgen products and services and/or my condition or treatment. Amgen may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or text message (standard text messaging rates may apply). I understand that I am not required to provide this consent as a condition of purchasing any goods or services.

My signature below certifies that I am at least 18 years old and that I have **read, understood, and agreed** 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: _____

## Amgen's Privacy Pledge to Patients

Amgen respects patients and customers and takes the protection of their privacy very seriously. Amgen pledges the following:

✓ Amgen does not and will not sell or rent your information to marketing companies or mailing list brokers.

✓ Amgen is careful to only collect and/or use personal identifiable information for the purposes stated in this Authorization and, as necessary, to provide the services and/or programs the patient or customer chooses to enroll into.

✓ Amgen practices are consistent with federal and state privacy laws, including HIPAA.

✓ Amgen program enrollment is voluntary and always provides patients with an easy option to cancel participation.



*Sensipar® Pharmacy Card Program Privacy Notice and Authorization continued on the next page.*

# OPTIONAL SENSIPAR® PHARMACY CARD PROGRAM DIRECT ENROLLMENT
## Privacy Notice and Authorization

Sensipar®
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*Continued from previous page*

### Uses and Disclosure of Personal Information

I authorize Amgen and its contractors and business partners ("Amgen") to use and/or disclose my personal information, *including my personal health information, only for the following purposes*:

- To operate, administer, enroll me in, and/or continue my participation in Amgen's Sensipar® Pharmacy Card Program or any other Amgen-affiliated patient support services and activities related to my condition or treatment (e.g., co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse educator services, adherence program, and disease management support);
- To contact, with my permission, my doctor and the rest of my healthcare team and share with them my health information that may be useful for my care;
- **To provide me with informational and promotional materials relating to Amgen products and services, and/or my condition or treatment;** and/or
- To improve, develop, and evaluate products, services, materials, and programs related to my condition or treatment.

In order for Amgen to provide me with the services and/or programs described above, Amgen needs to collect and use my personal information, including *my personal health information*. I understand that *my personal health information* may include any information, in electronic or physical form, in the possession of or derived from a healthcare provider, healthcare plan, pharmacy, pharmaceutical company, laboratory, and/or their contractor ("Healthcare Provider"). This may include select information from or about my medical history and general health, my healthcare plan benefits, payment limits or restrictions covered by my healthcare plan policy, and/or my adherence to my treatment.

I authorize my Healthcare Providers to disclose *my personal health information* to Amgen, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Healthcare Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen in exchange for disclosing *my personal health information* and/or for using my information to contact me with communications about Amgen products that have been prescribed to me (e.g., adherence programs) and other patient support services.

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

I understand that by signing this form, I authorize my Healthcare Providers or others who might hold my health information to only release it to Amgen employees, as well as to its contractors and business partners, who are performing the services set forth in this Authorization. I also understand I am authorizing my personal information, including *my personal health information*, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to release my personal health information for the earlier of five (5) years or until my participation in the program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling Amgen Assist® at 1-800-272-9376 or by writing to 2250 Perimeter Park Dr., Suite 300, Morrisville, NC 27560. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Healthcare Provider is disclosing my personal health information to Amgen on an authorized ongoing basis, my cancellation with Amgen will be effective with respect to any such Healthcare Providers as soon as they receive notice of my cancellation.

### No Effect on Treatment

I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary. I understand that Amgen, as well as Healthcare Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment or other care, to sign this Authorization. Federal Law (including HIPAA) requires a signed authorization in order for Amgen to collect this information from my Healthcare Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Healthcare Providers.

### Information Received From Healthcare Providers

I understand that once my personal health information has been disclosed to Amgen, federal privacy laws may no longer apply and protect it from further disclosure. Amgen agrees, however, to protect my personal health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law. I understand that Amgen does not and will not sell or rent my information to marketing companies or mailing list brokers.

AMGEN®