



CO-PAY AND PATIENT SUPPORT PROGRAM PATIENT AUTHORIZATION FORM

Please insert the 8-digit Prolia® Co-pay Program number located at the bottom left-hand side of the card

[PRL] _____
Program Number

Amgen's Patient Authorization

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 the Prolia® Co-pay Program or any other Amgen-affiliated patient support services and activities related to my condition or treatment (for example, 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 which have been prescribed to me (for example, medication reminder 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 at 1-844-369-9962, or by writing to ConnectiveRx, 100 Passaic Avenue, Suite 245, Fairfield, NJ 07004. 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 on-going 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.

Authorization to Contact

I understand and consent to Amgen contacting me using the contact information provided to Amgen or its contractors to enroll me in, operate, and administer Amgen patient support services and/or programs as described above other than promotional communications

by telephone or SMS/text (which I can separately opt-in below). I understand that the operation and administration of certain of these services and/or programs may require that Amgen contact me by telephone or SMS/text.

By signing below, I am indicating that I have read and understood Amgen's Privacy Notice and Authorization, that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal guardian for Amgen and its contractors and business partners to use and share the personal information I provide for the purposes described within the Privacy Notice and Authorization.

Telephone Consumer Protection Act (TCPA) Consent. 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 SMS/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. **Reply STOP to cancel SMS messages.**

Name of participant

Name of legal guardian (if needed)

Signature of participant (or legal guardian)

Date

Once the patient has read and signed this Authorization form, please fax it to 1-844-369-9961. Please be advised that the patient's Prolia® (denosumab) Co-pay Program Mastercard® will not be fully activated until Amgen confirms receipt of a faxed copy of this completed form.



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