Repatha*Ready*® Universal Patient Authorization Form

Fax this form back with the patient's demographic information and signature to: 1-855-REPATHA (1-855-737-2842).

RepathaReady® | Repatha® (evolocumab) injection 140 mg/mL

Patient Information	
Patient Name*: _____	Preferred Phone*: ( ) _____
Street Address*: _____	Email Address: _____
City*: _____ State*: _____ Zip*: _____	Date of Birth*: _____
	Social Security #: _____

Prescriber Information	
Office Contact: _____	Office Street Address*: _____
Email Address: _____	City*: _____ State*: _____ Zip*: _____
Prescriber Name*: _____	Telephone*: ( ) _____
Specialty: _____	Fax: ( ) _____
Office Name*: _____	Prescriber NPI #*: _____

Repatha*Ready*® Program 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 programs 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 certain of these services and/or programs 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.

Amgen may contact me using the contact information provided in this form for participation in market research activities associated with Amgen's products, services and/or my condition or treatment.

❑ I agree / ❑ I disagree

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: _____

* Required for processing.

Please see the next page for the **Repatha***Ready*® Program Privacy Notice and Authorization.

AMGEN®

Repatha*Ready*® Patient ID #: _____ **Physician NPI #:** _____

Repatha*Ready*® Program
Privacy Notice and Authorization

Repatha® (evolocumab) injection 140 mg/mL

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.

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 **Repatha*Ready*®** 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 health care provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor ("Health Care Provider"). This may include select information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I authorize my Health Care 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 Health Care 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 ex. 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 Health Care 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-REPATHA or by writing to PO Box 220326 Charlotte, NC 28222. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Health Care 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 Health Care 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 Health Care 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 Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

Information Received from Health Care 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®

Repatha*Ready*® Phone: 1-844-REPATHA (737-2842), Hours: 9 AM-9 PM ET, M-F; Fax: 1-855-REPATHA (737-2842)