Reset Form

Amgen SAFETY NET® Foundation
Sensipar™ (cinacalcet HCl) Application Form

PATIENT INFORMATION

_____
Patient Name

_____ _____
SSN DOB

_____
Address

_____
City, State, Zip

( ) _____ ( ) _____
Telephone Fax

PROVIDER INFORMATION

_____
Facility Name

_____
Address

_____
City, State, Zip

_____
Contact Name/Title

( ) _____ ( ) _____
Telephone Fax

_____
Physician Name

Ship Product to (check one):

☑ Provider Address Indicated on this Form
☐ Patient Address Indicated on this Form

Income:

$_____/year _____
Adjusted Gross Household Income Household size

I am a resident of the United States:

☐ Yes ☐ No

PRESCRIPTION INSURANCE (circle responses)

Medicaid:
Yes N/A Denied Pending Effective_____

Commercial:
Yes N/A Denied Pending Effective_____

VA/DOD:
Yes N/A Denied Pending Effective_____

State Kidney Program:
Yes N/A Denied Pending Effective_____

Other Insurer (please list by name):
Yes N/A Denied Pending Effective_____

Patient Authorization Statement: My doctor has prescribed Sensipar™ for me, and I would like to receive the drug free of charge through the SAFETY NET® Foundation. I hereby certify that the financial, insurance, and residency information listed on this form is accurate. This authorization expires the later of one year after the date of execution or one year after the last date I receive product under this program. I understand that this information identifying me will not be used for any purpose other than for the SAFETY NET® Foundation or to refer me to other available resources, such as Medicaid, VA, or state pharmacy assistance/kidney programs.

Print Patient Name _____/Legal Representative (if applicable)_____

Signature of Patient/Legal Representative_____ Date_____

Mail Completed Forms To: SAFETY NET® Foundation, P.O. Box 4133, Gaithersburg, MD 20885.
Phone: 800/272-9376 **Or Fax**: 888/508-8090