AMGEN® Support+

AVSOLA® (infliximab-axxq) INSURANCE VERIFICATION AND PRIOR AUTHORIZATION FORM

Fax with copies of insurance card(s), front and back, to
Amgen SupportPlus: **1-833-4-AVSOLA** (1-833-428-7652)

Patient Information

☐ New Patient to AVSOLA® ☐ Existing Patient

*Patient Name: ______

☐ Attach patient demographic sheet **OR** Complete information below:

*Street Address: ______

*City: ______ *State: ______ *Zip: ______

*Phone: ______

☐ M ☐ F *Date of Birth: ______

Email: ______

Prescribing Physician Information

*Physician Name: ______

*NPI #: ______ *Tax ID #: ______

Specialty: ______

*Enter Site ID: ______ **OR** Complete information below.

*Site Name: ______

*Street Address: ______

*City: ______ *State: ______ *Zip: ______

*Phone: ______

*Fax: ______

Office Contact: ______

Physician Email: ______

*Site Type: ☐ MD Office ☐ Hospital Outpatient

Therapy With AVSOLA®

Dosage/Frequency:

For Crohn's Disease, Pediatric Crohn's Disease, Ulcerative Colitis, Psoriatic Arthritis, Plaque Psoriasis:

☐ 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks

☐ Other: Dosage ______ Frequency ______

For Ankylosing Spondylitis:

☐ 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks

For Rheumatoid Arthritis (in conjunction with methotrexate):

☐ 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks

☐ Other: Dosage ______ Frequency ______

Patient weight ______kg # of vials to be used ______

Anticipated # of infusions ______

Fulfillment Method *(Select only ONE)*

☐ Medical Benefit (Physician Purchase)

☐ Referral to treating site

*Site ID: ______ **OR** Complete information below.

*Site Name: ______

*Site NPI #: ______ *Tax ID #: ______

*Street Address: ______

*City: ______ *State: ______ *Zip: ______

*Phone: ______

*Fax: ______

Office Contact: ______

*Site Type: ☐ MD Office ☐ Hospital Outpatient

Primary Insurance Information

☐ Attach a copy of insurance card, front **AND** back **OR** provide:

*Insurance Name: ______

*Insurance Phone: ______

Subscriber Name: ______

Subscriber Date of Birth: ______

Subscriber Relationship to Patient: ______

Group #: ______

*Policy #: ______

Secondary Insurance Information *(If Applicable)*

☐ Attach a copy of insurance card, front **AND** back **OR** provide:

*Insurance Name: ______

*Is this a Medigap policy? ☐ Yes ☐ No ☐ Not Known

If yes, please indicate plan letter: ______

*Insurance Phone: ______

Subscriber Name: ______

Subscriber Date of Birth: ______

Subscriber Relationship to Patient: ______

Group #: ______

*Policy #: ______

*Asterisk fields are required for processing.

Please see full Prescribing Information, including Boxed WARNINGS, and Medication Guide for AVSOLA®.

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.

Fax Completed Form and/or Copy of Insurance Card(s) to Amgen SupportPlus: **1-833-4-AVSOLA** (1-833-428-7652).

For any questions, please call (866) 264-2778.

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Primary Diagnosis *(Select ONE)*

- Crohn's Disease
  - ☐ K50.90 (Crohn's disease, unspecified, without complications)
  - ☐ Other ______________________
- Ulcerative Colitis
  - ☐ K51.80 (Other ulcerative colitis without complications)
  - ☐ Other ______________________
- Rheumatoid Arthritis
  - ☐ M05.9 (RA with rheumatoid factor, unspecified)
  - ☐ Other ______________________
- Ankylosing Spondylitis
  - ☐ M45.9 (Ankylosing Spondylitis of unspecified sites in spine)
  - ☐ Other ______________________
- Psoriatic Arthritis
  - ☐ L40.5 (Arthropathic psoriasis, unspecified)
  - ☐ Other ______________________
- Plaque Psoriasis
  - ☐ L40.0 (Psoriasis)
  - ☐ Other ______________________

Current Procedural Terminology (CPT)

Please select the primary CPT code associated with the infusion technique for AVSOLA®.

☐ **96413** Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug.

96415 Chemotherapy administration, intravenous infusion technique; each additional hour. Must be listed separately in addition to code for primary procedure.

☐ **96365** Intravenous infusion for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.

96366 Intravenous infusion for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour. Must be listed separately in addition to code for primary procedure.

☐ Other ______________________

The codes provided are not exhaustive or instructive and additional codes may apply.

Please NOTE: clinical notes and additional documentation are **NOT required** for us to process a patient benefit verification. Review of clinical documentation sent to Amgen SupportPlus could delay our response time back to your office. Please **DO NOT** provide anything beyond the information requested on this benefit verification form.

Affordability Screening

To see if the patient is eligible for additional affordability options, please complete the questions below

Residency:
Patient has lived in the U.S. or its territories (American Samoa, Guam, Puerto Rico, or U.S. Virgin Islands): ☐ Greater than 6 months ☐ Less than 6 months

Patient household income: $ ______________ ☐ Monthly ☐ Annually
(Gross income includes all individuals in the household. This includes wages, Social Security, Social Security disability, unemployment, pensions, and any other income. They may be asked to provide proof of income.)

How many people live in the patient's household (including the patient)?: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other ______________
Household size includes all individuals reported on the patient's U.S. Tax Return. If the patient did not file a tax return please include all individuals that live with them.

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