BKEMV® (eculizumab-aeeb) PATIENT ENROLLMENT FORM INSTRUCTIONS

Review the steps below to complete the Patient Enrollment form for prescription medicine, BKEMV.

Instructions:

1. Complete the following enrollment form in its entirety, including:
   - **a.** Patient information
   - **b.** Insurance information with copy of front and back of insurance card
   - **c.** Diagnosis and prescription information
   - **d.** Prescriber information
2. A signature is required from the patient's healthcare provider.
3. Fax pages 1-6 of this form, along with both sides of the patient's medical and prescription drug benefit cards, to the Amgen By Your Side team at 1 (866) 500-0987 or email to **BKEMVABYS@amgen.com**.
4. Check with your patient to ensure he or she has completed the required Patient Consent and Authorization for Amgen By Your Side in order to initiate patient support.
5. If you have any questions or comments, please contact Amgen By Your Side at **1 (866) 402-5622**.

AMGEN BY your side

BKEMV® (eculizumab-aeeb) PATIENT ENROLLMENT FORM

Once complete, submit pages 1-6 by fax 1-866-500-0987 or email BKEMVABYS@amgen.com

Complete all required fields, including prescriber's signature and date, to initiate patient enrollment process. For support and/or assistance obtaining patient signature, call Amgen By Your Side at 1-866-402-5622. (X Indicates a required field)

USA-959-80342 07/26

PATIENT INFORMATION

X **First name** | X **Last name**

X **Gender:** ○ Male ○ Female | X **Date of birth:** ___ /___ /_____ (MM/DD/YYYY)

X **Email address** | Primary language

X _____ ○ Primary **Mobile phone** | X _____ ○ Primary **Home phone**

X **Address**

X **City** | X **State** | X **ZIP code**

Alternate contact name | Alternate contact phone

INSURANCE INFORMATION

(Please include front and back copies of insurance card(s) with this form)

X **Primary insurance** | Secondary insurance

X **Policy #** | Policy #

X **Policyholder's first and last name** | Policyholder's first and last name

X **Insurance company phone** | Insurance company phone

X **Group #** | Group #

Policyholder's Date of birth: X ___ /___ /_____ (MM/DD/YYYY) | Policyholder's Date of birth: ___ /___ /_____ (MM/DD/YYYY)

○ Patient is uninsured to my knowledge.

RISK EVALUATION AND MITIGATION STRATEGY

BKEMV is available only through the BKEMV REMS, a restricted distribution program. To prescribe or dispense BKEMV, REMS certification is required.

- Healthcare providers who prescribe BKEMV must enroll and be certified in BKEMV REMS.
- Healthcare settings and pharmacies that dispense BKEMV must enroll and be certified in BKEMV REMS and must verify prescribers are certified.
- Patients are required to receive the required vaccinations per ACIP guidelines.

Please answer the following questions after enrolling at BKEMVREMS.com

Have you been certified as a prescriber in the BKEMV REMS program?

○ Yes

○ No (If no, go to BKEMVREMS.com to become REMS certified prior to prescribing BKEMV for your patient)

Has the patient been vaccinated according to ACIP Guidelines, or administered antibacterial drug prophylaxis if urgent BKEMV therapy was indicated?

○ Yes

○ No (If no, please review vaccination requirements per ACIP guidelines)

PRESCRIBER INFORMATION

X **First name** | X **Last name**

X **Address**

X **City** | X **State** | X **ZIP code**

X **NPI #** | X **State license #** | X **Tax ID #**

Clinic/hospital affiliation

X **Office contact name** | X **Office contact phone**

X **Office contact email address** | X **Fax number**

Prescriber specialty

Preferred communication ○ Phone ○ Email

PREFERRED INFUSION FACILITY

If none, Amgen By Your Side can provide options.

○ The infusion facility is the same as the prescribing office.

Facility name

Address

City | State | ZIP code

Phone | Fax number

Facility NPI # | Tax ID #

Complete prescription information and physician signature on next page

USA-959-80342 07/26

DIAGNOSIS AND CLINICAL INFORMATION

Select appropriate ICD-10 diagnosis code below (required for benefits investigation)

GENERALIZED MYASTHENIA GRAVIS (gMG)

- ○ G70.00: Myasthenia gravis without (acute) exacerbation
- ○ G70.01: Myasthenia gravis with (acute) exacerbation

Has the patient tested positive for AChR antibodies?

○ Yes ○ No

Neuromyelitis optica spectrum disorder (NMOSD)

- ○ ICD-10: G36.00 Neuromyelitis optica [Devic] (NMOSD)

Has the patient tested positive for ANTI-AQP4 antibodies?

○ Yes ○ No

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)

- ○ D59.5: Paroxysmal nocturnal hemoglobinuria

ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS)

- ○ D59.30 Hemolytic-uremic syndrome, unspecified
- ○ D59.32: Hereditary hemolytic uremic syndrome
- ○ D59.39: Other hemolytic uremic syndrome

Medications tried/previous therapy:

- ○ Azathioprine
- ○ Efgartigimod
- ○ Iptacopan
- ○ IVIg
- ○ Mycophenolate Mofetil
- ○ Plasmapheresis
- ○ Prednisone
- ○ Pyridostigmine
- ○ Rituximab
- ○ Ravulizumab
- ○ None/new diagnosis
- ○ Other: _____

Is patient switching from SOLIRIS® (eculizumab)?

- ○ Yes
- ○ No

PRESCRIPTION (Required)

X _____ **Patient first name**

X _____ **Patient last name**

X ____ / ____ / _____ **Date of Birth** (MM/DD/YYYY)

Prescription Information: BKEMV (eculizumab-aeeb)

Allergies: _____ ○ No known drug allergies (NKDA)

NDC: 55513-180-01: Single-dose vial of 300 mg of BKEMV in 30 mL (10 mg/mL)

Patient Weight: _____ ○ lbs or ○ kg

Note: For patients switching from SOLIRIS® to BKEMV, no induction dose required. Patient can start on maintenance dose 2 weeks (+/- 2 days) after last dose of SOLIRIS®.

○ Rx BKEMV 10 mg/mL HCPCS Code: Q5152 Per Unit

Induction Dose:

SIG: infuse intravenously _____ mg weekly for the first 4 weeks, followed by _____ for the 5th week.

○ Other: _____

QTY of 300 mg/30 mL Vials: _____ Refills: 0

Maintenance Dose:

SIG: infuse intravenously _____ mg every 2 weeks. Start 2 weeks after the 5th week's dose is complete

○ Other: _____

QTY of 300 mg/30 mL Vials: _____ Refills: _____

○ **No induction dose; patient is on therapy**

Administration instructions: Administer only as an intravenous (IV) infusion. *Do not administer as an intravenous push or bolus*. Administer over 35 minutes in adults and 1 to 4 hours in pediatric patients via gravity feed, a syringe-type pump, or an infusion pump.

Admixed solutions of BKEMV are stable for 64 hours at 2°C to 8°C (36°F to 46°F) or 24 hours at room temperature.

State requirements: The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

Signature below indicates prescription authorization and prescriber certification.

X _____ **Prescriber signature/Dispense as written**

Written or e-signature only; stamps not acceptable.

_____ Prescriber signature (substitutions allowed)

X ___ / ___ / _____ **Date** (MM/DD/YYYY)

Prescriber Certification: I certify that the above therapy is medically necessary, that the information provided is accurate to the best of my knowledge and that my patient is being administered BKEMV in accordance with the labeled use of the product. I represent that my patient has requested and authorized the disclosure of their personal information to Amgen, Inc. and its affiliates and their respective employees or agents (collectively, "Amgen") for Amgen to administer the Amgen By Your Side program (the "Program"), which provides patient-focused support, including providing logistical and non-medical treatment support for BKEMV, as prescribed, and educating about the insurance process. I further represent that I have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Amgen will use the patient's name, date of birth, contact information, prescriptions, and other necessary health information to administer the Program; 2) Amgen will then disclose the patient's personal information to the patient's insurer(s) for the same purposes; 3) the patient can withdraw their consent by contacting Amgen at 1-844-469-4297 or visiting www.amgen.com/DataSubjectRights, but if the patient does not agree to, or withdraws consent for, these uses and disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Amgen to process the patient's personal information; and 4) the patient can view more details about Amgen's privacy practice at www.amgen.com/privacy. I authorize Amgen to transmit this prescription on my behalf to the appropriate pharmacy designated by the patient utilizing their benefit plan by any means allowed under appliable law. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use BKEMV or any other Amgen product or service, for any other person; (b) my decision to prescribe BKEMV was based solely on my professional determination of medical necessity; and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Amgen may modify or terminate the Program at any time without notice. The completion and submission of coverage- or reimbursement-related documentation are the responsibility of the patient and healthcare provider. Amgen makes no representation or guarantee concerning coverage or reimbursement for any item or service. On behalf of the patient, Amgen expects the prescriber to coordinate with Amgen By Your Side to provide, to the best of the prescriber's ability, in-network infusion services and work with Amgen By Your Side to effectively communicate both in-network and out-of-network choices and the corresponding financial obligations of the patient connected to each choice. Should the prescriber knowingly perform out-of-network services without the knowledge and consent of the patient, the prescriber cannot balance bill the patient for the out-of-network services.

State requirements: I certify that the prescription I am submitting as part of this Patient Enrollment Form complies with my state's prescription requirements (e.g., e-prescribing, state-specific prescription form, fax language). I understand that noncompliance with my state's specific prescription requirements will result in outreach to me to obtain a compliant prescription.

By filling out and signing this form, the enrollment process in Amgen By Your Side has initiated; however, your patient must sign a Patient Authorization to complete enrollment in Amgen By Your Side. Please note that your patient will not benefit from the services and support offered by the Program unless your patient signs a Patient Authorization, consenting to receiving such services. If your patient does not sign the Patient Authorization contained within this form, Amgen will contact the patient to determine whether the patient is interested in signing a separate Patient Authorization.

This page is to be completed by the patient. If the patient is unable to complete this page in-office, Amgen By Your Side can reach out to obtain patient consent.

USA-959-80342 07/26

X _____ **Patient first name**

X _____ **Patient last name**

X ____ / ____ / _____ **Date of Birth** (MM/DD/YYYY)

PATIENT CONSENT AND AUTHORIZATION (Required—please see language on pages 4-5.)

You must read the Consent to Health Data Processing on page 5 and then select one of the below responses. **Select "I consent" to proceed with enrollment. If you select "I do not consent," you will not be able to enroll in Amgen By Your Side**

- ◯ **I consent to the collection, processing, and disclosure of my Health Data for the purposes set forth on page 5.**
- ◯ **I do not consent to the collection, processing, or disclosure of my Health Data for the purposes set forth on page 5.**

By signing below, I am indicating that I have read and understood the Authorization for Use and Disclosure of Protected Health Information (pages 4-5), that I am legally authorized to consent, and that I am providing my consent as the patient or the patient's legal representative for Amgen and its contractors and business partners to use and share the personal information I provide for the purposes described within the Authorization for Use and Disclosure of Protected Health Information.

X _____ **Patient name**

_____ Name of Legal Representative (if needed)

X _____ **Signature of Patient (or Legal Representative)**

X ____ / ____ / _____ **Date** (MM/DD/YYYY)

Is there someone else with whom we can discuss your protected health information? ◯ Yes ◯ No

_____ Name

_____ Relationship

_____ Phone number

CO-PAY PROGRAM ENROLLMENT (Complete this section if you want to apply for the Amgen SupportPlus Co-Pay Program)

To check eligibility for the Amgen® SupportPlus Co-Pay Program you must answer the questions below and agree to the Terms & Conditions by checking the box below.

What type of insurance do you use to pay for your BKEMV prescription and administration at the doctor's office?
(Please select one option)

- ◯ Commercial insurance (eg, self-purchased or through an employer)
- ◯ Government-provided (eg, Medicare Part D, Medicaid)
- ◯ I don't have insurance
- ◯ I don't know

Are you eligible for Medicare but receive prescription drug coverage from a former employer, union, or welfare plan?

- ◯ Yes
- ◯ No

- ◯ By checking this box, I agree that I have read, understand, and accept the Terms & Conditions of the Amgen SupportPlus Co-Pay Card Program on page 6.

USA-959-80342 07/26

Uses and Disclosure of Protected Health Information

I authorize Amgen and its data processors (collectively, "Amgen") to collect, use, and disclose my protected health information for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in the Amgen By Your Side 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, patient access liaison services, adherence program and disease management support);
- To contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care;
- To improve, develop, and evaluate Amgen's 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 protected health information. I understand that my protected 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 (each, a "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 protected 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 protected 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 Health Care Providers or others who might hold my health information to disclose it to Amgen. I also understand I am authorizing my personal information, including my protected 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 disclose my protected health information for the earlier of five (5) years or until my participation in the Amgen By Your Side 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 1-844-469-4297 or by writing to Amgen By Your Side, 1 Horizon Way, Deerfield, IL 60015. If I cancel this Authorization, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my protected health information to Amgen in reliance on this Authorization on an 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 my protected health 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 protected health information has been disclosed to Amgen, federal privacy laws may no longer apply and may no longer protect it from further disclosure, and that Amgen may disclose my protected health information to its data processors, contractors, and business partners for its business purposes. Amgen agrees, however, to protect my protected health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

U.S. STATE LAW CONSENT TO PROCESS HEALTH DATA FOR AMGEN BY YOUR SIDE

Please read and provide response in Patient Consent and Authorization section on page 3

I consent to Amgen processing my Health Data for the following purposes:

- To enroll me and manage my participation in the Amgen By Your Side program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, patient access liaison support, disease management support), and to manage Amgen's products, services, and programs related to my condition or treatment.

Amgen uses the following when it administers the Amgen By Your Side program:

- Health Data – my name (and the name of my caregiver if applicable), gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that my consent to processing is required for me to participate in the Amgen By Your Side program. I also understand that Amgen will not sell my Health Data to third parties, but Amgen may disclose my Health Data to Amgen's data processors, contractors, and business partners for Amgen's business purposes related to the Amgen By Your Side program. I understand that Amgen may use my Health Data to contact me by mail, email, telephone, or text for the above purposes. Mobile Terms & Conditions can be found at AmgenByYourSide.com/mobile-terms-and-conditions. I also understand that if I do not consent to the use of my Health Data for the above purposes, I will not be able to participate in the Amgen By Your Side program. Finally, I understand that I may withdraw my consent to processing my Health Data for the above purposes at any time using one of the methods listed in the Additional Disclosures section below and that if I withdraw my consent, I will no longer be able to participate in the Amgen By Your Side program.

Additional Disclosures

I understand that participation in the Amgen By Your Side program is an optional service at no cost to me. The consent above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications. To obtain a copy of the consent above or to withdraw my consent to collection, processing, and/or disclosure of my Health Data for any of the above purposes to which I have consented, I can contact Amgen by visiting www.amgen.com/DataSubjectRights or calling 1-844-469-4297. For more information about Amgen's privacy practices, Amgen's Privacy Statement can be found at http://www.amgen.com/privacy

Amgen® SupportPlus Co-Pay Card Terms and Conditions

It is important that every patient read and understand the full Amgen SupportPlus Co-Pay Card Terms and Conditions. The following summary is not a substitute for reviewing the Terms and Conditions in their entirety.

As further described below, in general:

- The Amgen SupportPlus Co-Pay Card is open to patients with commercial insurance that covers BKEMV® (eculizumab-aeeb), regardless of financial need. The program is not valid for patients whose prescription and/or in-office administration costs for BKEMV is paid for in whole or in part by Medicare, Medicaid, or any other federal or state healthcare program. The Amgen SupportPlus Co-Pay Card cannot be combined with any other savings, free trial, free goods or similar offer related to BKEMV. It is not valid for cash paying patients or where prohibited by law. (See ELIGIBILITY section in the full Terms & Conditions.)
- The Amgen SupportPlus Co-Pay Card may help lower your BKEMV out-of-pocket medication and in-office administration costs. Patients who are residents of Massachusetts or Rhode Island are not eligible for administration support. Out-of-pocket costs may include co-payment, co-insurance, and deductible out-of-pocket costs. The Amgen SupportPlus Co-Pay Card does not cover any other costs related to office visits. The Amgen SupportPlus Co-Pay Card provides support up to the Maximum Program Benefit or Patient Total Program Benefit. If a patient's commercial insurance plan imposes different or additional requirements on patients who receive Amgen SupportPlus Co-Pay Card benefits, Amgen has the right to modify or eliminate those benefits. Whether you are eligible to receive the Maximum Program Benefit or Patient Total Program Benefit is determined by the type of plan coverage you have. Please ask your Amgen SupportPlus Representative to help you understand eligibility for the Amgen SupportPlus Co-Pay Card, whether your particular insurance coverage is likely to result in your reaching the Maximum Program Benefit or your Patient Total Program Benefit amount by calling (866) 264-2778. (See PROGRAM BENEFITS section in the full Terms & Conditions.)
- Amgen SupportPlus patients may pay as little as $0 out-of-pocket for each dose of BKEMV. Patients may also receive up to $1,000 per calendar year for out-of-pocket costs for in-office administration of BKEMV. Patients who are residents of Massachusetts or Rhode Island are not eligible for administration support.

Amgen will pay the remaining eligible out-of-pocket costs on behalf of the patient until the Amgen payments have reached either the Maximum Program Benefit and/or the Patient Total Program Benefit. Patients are responsible for all amounts that exceed this limit. Please ask your Amgen SupportPlus Representative to help you understand eligibility for the Amgen SupportPlus Co-Pay Card by calling (866) 264-2778. (See PROGRAM DETAILS section in the full Terms & Conditions.)

Program coverage through the Amgen SupportPlus Co-Pay Card is contingent on
(1) the submission of the required Explanation of Benefits (EOB) form within 180 days of the date of approval documented on the EOB for medical benefit claims or
(2) the submission of the claim within 180 days of the date of service for pharmacy benefit claims. (See PROGRAM DETAILS section below.)

I. ELIGIBILITY

***Eligibility Criteria: Subject to program limitations and terms and conditions**, the Amgen SupportPlus Co-Pay Card is open to patients who have been prescribed BKEMV and who have commercial or private insurance that covers BKEMV, including state and federal plans commonly referred to as "healthcare exchange plans." This program helps eligible patients cover out-of-pocket medication costs related to BKEMV, up to program limits. The Amgen SupportPlus Co-Pay Card does not cover any other costs related to office visits. There is no income requirement to participate in this program.

This offer is not valid for patients whose prescription for BKEMV is paid for in whole or in part by Medicare, Medicaid, or any other federal or state healthcare program. The Amgen SupportPlus Co-Pay Card cannot be combined with any other savings, free trial, free goods or similar offer related to BKEMV.
It is not valid for cash-paying patients or where prohibited by law. A patient is considered cash-paying where the patient has no insurance coverage for BKEMV or where the patient has commercial or private insurance but Amgen in its sole discretion determines the patient is effectively uninsured because such coverage does not provide a material level of financial assistance for the BKEMV prescription. This offer is only valid in the United States, Puerto Rico, and the US territories.

II. PROGRAM BENEFITS

The Amgen SupportPlus Co-Pay Card may modify the benefit amount, unilaterally determined by Amgen in its sole discretion, to satisfy the out-of-pocket cost sharing requirement for any patient whose plan or plan agent (including, but not limited to, a Pharmacy Benefit Manager (PBM)) requires enrollment in the Amgen SupportPlus. Co-Pay Card as a condition of the plan or PBM waiving some or all of an otherwise applicable patient out-of-pocket cost sharing amount. These programs are often referred to as co-pay maximizer programs. **If you believe your commercial insurance plan may have such limitations, please contact Amgen SupportPlus Support at (866) 264-2778**. Health plans and Pharmacy Benefit Managers are prohibited from enrolling patients or assisting in the enrollment of patients in the Amgen SupportPlus Co-Pay Card. **The patient, or his/her legal representative, must personally enroll in the Amgen SupportPlus Co-Pay Card in order to be eligible for program benefits.**

If at any time a patient begins receiving coverage for medications or in-office administration under any federal, state, or government healthcare program (including but not limited to Medicare, Medicaid, TRICARE, Department of Defense, or Veteran Affairs programs), the patient will no longer be able to use this card and you must contact **Amgen SupportPlus at (866) 264-2778** (Monday through Friday, from 9am to 8pm ET) to stop your participation in this program.

Patients may not seek reimbursement for the value received from the Amgen SupportPlus Co-Pay Card from any third-party payers, including a flexible spending account or healthcare savings account. Participating in this program means that you are ensuring you comply with any required disclosure regarding your participation in the Amgen SupportPlus Co-Pay Card of your insurance carrier or pharmacy benefit manager. Restrictions may apply. Offer subject to change or discontinuation without notice. **This is not health insurance.**

III. PROGRAM DETAILS

For all eligible patients the Amgen SupportPlus Co-Pay Card offers:

- A program benefit that covers the patient's eligible out-of-pocket medication and in-office administration costs for BKEMV (co-pay, deductible, or co-insurance) on behalf of the patient, up to a Maximum Program Benefit determined by the program per calendar year. The Amgen SupportPlus Co-Pay Card does not cover any other costs related to office visits.
- Amgen SupportPlus patients may pay as little as $0 out-of-pocket for each dose of BKEMV. Patients may also receive up to $1,000 per calendar year for out-of-pocket costs for in-office administration of BKEMV. Patients who are residents of Massachusetts or Rhode Island are not eligible for administration support

Amgen will pay the remaining eligible out-of-pocket prescription costs on behalf of the patient until the Amgen payments have reached either the Maximum Program Benefit and/or the Patient Total Program Benefit. Patients are responsible for all amounts that exceed this limit.

Program coverage through the Amgen SupportPlus Co-Pay Card is contingent on
(1) the submission of the required Explanation of Benefits (EOB) form within 180 days of the date of approval documented on the EOB for medical benefit claims or
(2) the submission of the claim within 180 days of the date of service for pharmacy benefit claims.

Maximum Program Benefit, Patient Total Program Benefit, Benefits May Change, End or Vary Without Notice: The program provides up to a **Maximum Program Benefit** of support to reduce a patient's out-of-pocket medication costs that Amgen will provide per patient for each calendar year, which must be applied to the Amgen SupportPlus patient's out-of-pocket costs (co-pay, deductible, or co-insurance and annual out-of-pocket maximum). **Patient Total Program Benefit** amounts are unilaterally determined by Amgen in its sole discretion and will not exceed the Maximum Program Benefit. The Patient Total Program Benefit may be *less than* the Maximum Program Benefit, depending on the terms of a patient's plan, and *may vary among individual patients covered by different plans*, based on factors determined solely by Amgen, to ensure all programs funds are used for the benefit of the patient. Each patient is responsible for costs above the Patient Total Program Benefit amounts. Please ask your Amgen SupportPlus Representative to help you understand whether your particular insurance coverage is likely to result in your reaching the Maximum Program Benefit or your Patient Total Program Benefit amount by calling **(866) 264-2778**. Participating patients are solely responsible for updating Amgen with changes to their insurance including, but not limited to, initiation of insurance provided by the government, the addition of any coverage terms that do not apply Amgen SupportPlus Co-Pay Card benefits to reduce a patient's out-of-pocket costs, such as accumulator adjustment benefit design or a co-pay maximization program. Participating patients are responsible for providing Amgen with accurate information necessary to determine program eligibility. By accepting payments from Amgen made on behalf of participating patients, participating PBMs and Plans likewise are responsible for providing Amgen with accurate information regarding patient eligibility.

Patients may use the card every time they receive a dose of BKEMV, up to the Maximum Program Benefit or Patient Total Program Benefit. Benefits reset each calendar year. Re-enrollment in the program is required at regular intervals. Patients may continue in the program as long as patient re-enrolls as required by Amgen and continues to meet all of the program's eligibility requirements during participation in the program. Patients can enroll/reenroll by calling **(866) 264-2778**.

AMGEN

Once complete, submit pages 1-6 by fax 1-866-500-0987 or email BKEMVABYS@amgen.com

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