Hospitals and prescribers in private practice clinics that are enrolled in the ESA APPRISE Oncology Program may modify the Acknowledgment Form and present the modified form to patients in either paper or electronic form, provided that the Acknowledgment Form conforms with the following criteria:

- Removal of title, instructions, and footnoted text
- Addition of patient identifier and/or clinic/hospital identifiers (e.g., name and/or logo, barcodes)
- Changes to make the form compatible with existing systems, including electronic- and paper-based systems

NO changes should be made to boxed content

The hospital or private practice must maintain evidence of compliance that the Acknowledgment Form was signed by both the patient and the prescriber prior to the initiation of a new course of ESA therapy. Private practices must provide the completed forms to the ESA APPRISE Oncology Program Call Center.

Guidelines for Patient Acknowledgment Form Integration Within Healthcare Systems and Clinics

For the use of erythropoiesis stimulating agents (ESAs) Aranesp® (darbepoetin alfa), Epogen® (epoetin alfa), or Procrit® (darbepoetin alfa) in patients with cancer

Instructions for Healthcare Providers

1. Review the contents of the appropriate Medication Guide with your patient.
2. Counsel your patient on the risks and benefits of Aranesp® or Epogen® or Procrit®. Balance each new course of ESA therapy.
3. Complete each section of the form as required with your patient.

In hospital

Provide the completed form (or modified version consistent with the allowable changes) to the ESA APPRISE Oncology Program Call Center at 1-866-553-8124 to ensure that the patient is counseled on the risks and benefits of the ESA drug and is instructed to sign the Acknowledgment Form.

In practice

Provide the completed form (or modified version consistent with the allowable changes) to the hospital or private practice responsible for maintaining and storing the forms or the forms may be archived electronically through an electronic medical record system as long as they are retrievable.

Patient Acknowledgment of Receipt of Aranesp®, Epogen®, or Procrit® Medication Guide and ESA Risk/Benefit Discussion and Authorization for Release of this Acknowledgment Form (Required)

I acknowledge that prior to receiving my first dose of Aranesp® or Epogen®/Procrit® therapy:

- Aranesp® and Epogen®/Procrit® are different drugs and your doctor will decide which one is right for you.
- I understand that prior to receiving my first dose of Aranesp® or Epogen®/Procrit® therapy:
- I have read and understand the Aranesp® or Epogen®/Procrit® Medication Guide that my healthcare professional has given to me.
- I have had all my questions or concerns about Aranesp® or Epogen®/Procrit® answered by my healthcare professional.
- I am aware that using Aranesp® or Epogen®/Procrit® may make my tumor grow faster or I may get serious heart problems such as heart attack, stroke, heart failure, or blood clots, and I may die sooner.
- I hereby authorize my healthcare provider to release and disclose this Acknowledgment Form or a copy of this Acknowledgment Form to the Program Sponsors (Amgen and Janssen Products, LP) and their contractors and data management administrator (Administrator) solely for the purpose of allowing the Program Sponsors and Administrator to monitor compliance with the Program.
- The Administrator to maintain my Healthcare Professional to collect, enter and maintain my Acknowledgment Form information in a database and to make submissions to government agencies, including the FDA, regarding Program effectiveness, or as required by law.

I understand that since my Acknowledgment Form information has been disclosed to the Program Sponsors and Administrator, federal and state laws may no longer protect the information and it may be subject to re-disclosure. However, the Program Sponsors and Administrator agrees to protect my information by using it and disclosing it only for the purposes described above.

I understand that I may revoke this Authorization at any time by accessing the ESAs at the ESA APPRISE Oncology Program Call Center at 1-866-553-8124.

I understand that this Authorization expires ten (10) years from the date of my signature, or earlier if required by applicable law. Further, I understand I have a right to receive a copy of this Authorization.

Healthcare Professional Acknowledgment (Required)

Date (MM/DD/YY)

Signature of prescriber

Date (MM/DD/YY)

Signature of patient or patient representative

Printed patient name

Printed name of patient representative

Address (City, State, Zip)

Site Address (Address, City, State, Zip)

Site Name

Expiration data (MM/DD/YY)

Annotated printed page