AstraZeneca Access 360™ Patient Authorization Form

Access 360 is an optional program provided by AstraZeneca for patients, their caregivers, family, and providers. Access 360 can help you understand your coverage and financial obligation for AstraZeneca medicines and provide you with resources to help with treatment and payment for treatment.

By signing below, I authorize my health care providers and staff, my health plan, and my pharmacies to use and share Protected Health Information (my "Information") with AstraZeneca (including Access 360) and its affiliates, as well as its contractors ("AstraZeneca"). My Information includes my prescription-related health records, information about my health care plan benefits, and any other information bearing on my health. My Information may be used to verify, investigate, and assist with coordination of coverage for AstraZeneca products; track my prescription as requested by my physician; contact me about patient assistance programs; and perform internal analysis at AstraZeneca to better meet patient needs. I understand that federal privacy laws may not protect my Information once it is disclosed; however, AstraZeneca agrees to protect my Information by using and disclosing it only for purposes specified. I understand that I can refuse to sign this Authorization and that this will not affect my treatment or payment for treatment, insurance coverage, or eligibility for benefits. However, if I do not sign this Authorization, I will not be able to receive Access 360 support. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to One MedImmune Way, Gaithersburg, MD 20878. I understand that any such cancellation will not apply to any Information already used or disclosed based on this authorization prior to their receipt of the cancellation.

Patients are entitled to a signed copy. This authorization expires two (2) years from the date signed below, unless a shorter period is required by state law.

For completion by Patient or Legally Authorized Representative

Patient Name (First Last): _____ Patient DOB: _____

Legally Authorized Representative Name (First Last): _____

Email Address: _____

Mailing Address Street/Apt: _____

City/State/ZIP: _____

Relation to Patient: ☐ Patient ☐ Legally Authorized Representative of Patient

Patient or Legally Authorized Representative Signature: _____ **Date:** _____

This authorization is also available online at **www.MyAccess360PAF.com**.

About AstraZeneca Access 360™

AstraZeneca Access 360™ provides you with free personal support to help you so you can have access to the medicines you need. We will make every effort to work with you to help you navigate complicated financial and insurance questions. Our knowledgeable and compassionate Reimbursement Counselors will try to provide you with the support you need so you don't have to miss a dose.

We can help you with:

- Complicated insurance questions and processes
- Locating a pharmacy
- Finding the financial help that is right for you
- Providing information about support programs that you may be eligible for if you don't have, or have been denied, insurance coverage

Call today to meet your AstraZeneca Reimbursement Counselor at ***844-ASK-A360 (844-275-2360)*** Monday - Friday 8AM-8PM ET. For additional information, visit ***www.MyAccess360.com.***

How to Submit the Patient Authorization Form (PAF):

To initiate Access 360 patient-specific support, fill out and submit a ***Patient Authorization Form (PAF).*** PAFs can be submitted in five ways:

By paper, faxed to ***844-FAX-A360*** (844-329-2360)

By paper, mailed to AstraZeneca Access 360, ***One MedImmune Way, Gaithersburg, MD 20878***

Online, at ***www.MyAccess360PAF.com***

Verbally, by calling ***844-ASK-A360*** (844-275-2360)

Visit us online at **www.MyAccess360.com** to learn more.

AstraZeneca Access 360™