AstraZeneca Access 360™

Enrollment Form

Patient Name: _____

AstraZeneca's Access 360™ program provides personal support to connect patients to affordability programs and to streamline access and reimbursement for AstraZeneca's medicines.

1-844-ASK-A360
(1-844-275-2360)

1-844-FAX-A360
(1-844-329-2360)

www.MyAccess360.com

About This Form:

Use this form to enroll into Access 360 support and AstraZeneca's affordability programs. Once completed and signed, fax form to 1-844-329-2360. You may need to provide additional information depending on the type of support requested.

Please see below for more information and a guide to what information can be found in each section:

SECTION 1: *Patient Authorization*

SECTION 2: *Patient Information / Insurance Information*

SECTION 3: *Provider Information*

SECTION 4: *Prescription Information*

SECTION 5: *AstraZeneca Patient Savings Program*

Select an AstraZeneca Medicine:

- ☐ ARIMIDEX® (anastrozole)
- ☐ CALQUENCE® (acalabrutinib)
- ☐ CASODEX® (bicalutamide)
- ☐ FASLODEX® (fulvestrant)
- ☐ IMFINZI® (durvalumab)
- ☐ IRESSA® (gefitinib)
- ☐ LYNPARZA® (olaparib)
- ☐ TAGRISSO® (osimertinib)

Select Support | Check all boxes that apply: ☐ Select All Comments: _____

- ☐ **Access 360 Patient Authorization** ..... SECTION 1
- ☐ **Benefits Investigation** ..... SECTION 1, 2 & 3
- ☐ **Prior Authorization** ..... SECTION 1, 2 & 3
- ☐ **Claims and Appeal Support** ..... SECTION 1, 2 & 3
- ☐ **Pharmacy Coordination** ..... SECTION 1, 2, 3 & 4
- ☐ **Affordability Support** (AstraZeneca Patient Savings Program) ..... SECTION 1, 2, 3 & 5
- ☐ **Free Limited Supply** ..... SECTION 1, 2, 3 & 4
- ☐ **Access 360 Portal** (also available at www.MyAccess360Portal.com) ..... SECTION 3

Patient Name:

Phone: 1-844-ASK-A360 (1-844-275-2360) • **Fax:** 1-844-FAX-A360 (1-844-329-2360)
Online: www.MyAccess360.com • **Mail:** One MedImmune Way, Gaithersburg, MD 20878

AstraZeneca Access 360™

SECTION 1 *Patient Authorization*

Access 360 Patient Authorization:

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 typing my name 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.

Patient Name (First, Last): _____
Patient DOB: _____
Phone #: _____
Address: _____

Physician Name (First, Last): _____
Phone #: _____
Address: _____

*Signature of Patient/Legally Authorized Representative _____ *Date _____

This authorization expires two (2) years from the date I sign this form unless a shorter period is required by state law.

Optional Enrollment:

- ☐ CALQUENCE® (acalabrutinib)
- ☐ IMFINZI® (durvalumab)
- ☐ IRESSA® (gefitinib)
- ☐ LYNPARZA® (olaparib)
- ☐ TAGRISSO® (osimertinib)

☐ By checking this box and completing the information above, I certify that I am at least 18 years old and would like to receive information about my prescribed therapy, and related health information from AstraZeneca.

By completing this registration, I understand that I may also receive ongoing information and support related to my condition including treatment information. This may include AstraZeneca or a third party working on AstraZeneca's behalf contacting me by telephone regarding AstraZeneca support programs that may be of interest to me.

Information provided by AstraZeneca does not take the place of talking to your healthcare provider about your treatment or condition. AstraZeneca or third parties working on its behalf will not sell or rent your personal information. If in the future, you no longer want to receive these materials or calls, or to report a medication side effect, please call 1-800-236-9933. Please visit www.azprivacynotice.com to review our Privacy Notice.

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SECTION 2 *Patient Information / Insurance Information*

Patient Information

Name (First, Last):

Patient DOB:

Gender: ☐ Male ☐ Female

Primary Language: ☐ English ☐ Spanish ☐ Other:

Address Street:

City: State: ZIP:

Patient Home Phone #:

Patient Mobile Phone #:

Patient Email Address:

Caregiver 1 Name/Relationship to Patient: /

Caregiver 1 Phone #:

Caregiver 2 Name/Relationship to Patient: /

Caregiver 2 Phone #:

Insurance Information

☐ No Insurance ☐ Copies of front and back of Medical and Pharmacy cards
(If copies are included, you do not need to rewrite card information)

	Primary Insurance	Secondary Insurance	Pharmacy Benefit
Insurance Provider Name:			
Insurance Phone #:			
Name (If not patient):			
Cardholder DOB:			
Policy #:			
Group #:			
BIN #:			
PCN #:			

Income Information (Optional)

SSN: ____/____/____ Number of people in your household: _____ *(Include yourself, spouse, and dependents)*

What is your total combined household income before taxes? *(Include yourself, spouse, and dependents)*

$ _____ Monthly OR $ _____ Yearly

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SECTION 3 *Provider Information*

Provider Information

Diagnosis Code: _____

	Provider Practice	Treatment Practice* **Optional if patient is referred to another place of administration*
Prescriber Name:		
Practice Name:		
Office Contact Name:		
Practice Address Street:		
City:		
State/ZIP:	/	/
Phone # 1:		
Phone # 2:		
Fax #:		
Email Address:		
Prescriber Specialty:		
Prescriber NPI #:		
Group NPI #:		
Tax ID #:		
License #:		
DEA #:		
Medicare Provider #:		
Medicaid Provider #:		
Provider Transaction Access Number (PTAN):		
Alternative Office Contact Name:		
Alternative Contact Phone #:		

Sign and Date

By signing this form, I certify that (1) I have received the necessary authorization to release the information included on this form and other related Protected Health Information (as defined by HIPAA) to AstraZeneca's Access 360, including employees, contractors, or affiliates of AstraZeneca, and health care plans for programs, dispensing pharmacy(ies) or other entities, for the purposes of treatment and payment support, and (2) I have obtained any necessary authorization to allow AstraZeneca Access 360 to contact the patient, if not included with this submission, to obtain a signed Access 360 Patient Authorization Form.

Provider Name: _____

Provider Signature: _____ **Date:** ____ / ____ / ____

Patient Name: _____

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SECTION 4 *Prescription Information*

Prescription Information

Has prescription already been submitted to pharmacy? ☐ Yes ☐ No ☐ Do Not Know
If Yes, please indicate where: ☐ Accredo ☐ Avella ☐ Biologics ☐ CVS Specialty ☐ Diplomat ☐ In-Office ☐ US Bioservices ☐ Do Not Know ☐ Other: _____

☐ CALQUENCE® (acalabrutinib) ☐ 100-mg capsule Quantity _____ Refills _____
Specialty Pharmacy Provider (SPP): ☐ Avella ☐ Biologics ☐ Diplomat ☐ Onco360 ☐ No Preference*
**If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-844-275-2360.*

☐ IMFINZI® (durvalumab) Dispense: ☐ 500 mg/10 mL vial ☐ 120 mg/2.4 mL vial
Administer 10 mg/kg as an intravenous infusion over 60 minutes every 2 weeks
Refill: _____ times.
Specialty Pharmacy Provider (SPP): ☐ Accredo ☐ Avella ☐ Biologics ☐ CVS Specialty ☐ Diplomat ☐ US Bioservices ☐ No Preference*
**If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-844-275-2360.*

☐ IRESSA® (gefitinib) 250-mg tablet Quantity _____ Refills _____
☐ TAGRISSO® (osimertinib) 80-mg tablet Quantity _____ Refills _____
☐ TAGRISSO
Dose adjustment: 40-mg tablet Quantity _____ Refills _____
Dose instructions _____
Specialty Pharmacy Provider (SPP): ☐ Accredo ☐ Avella ☐ Biologics ☐ CVS Specialty ☐ Diplomat ☐ US Bioservices ☐ No Preference*
**If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-844-275-2360.*

☐ LYNPARZA® (olaparib) ☐ 150-mg tablets Quantity _____ Refills _____
☐ LYNPARZA
Dose adjustment: ☐ 100-mg tablets Quantity _____ Refills _____
Dose instructions _____

☐ LYNPARZA® (olaparib) ☐ 50-mg capsules Quantity _____ Refills _____
Dose instructions _____
Specialty Pharmacy Provider (SPP): ☐ Accredo ☐ Biologics ☐ No Preference*
**Capsules only available through SPP(s). If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-844-275-2360.*

To avoid substitution errors and overdose, **do not substitute LYNPARZA tablets with LYNPARZA capsules** on a milligram-to-milligram basis due to differences in the dosing and bioavailability of each formulation.

Medicine Name: _____ Dose: _____ Quantity: _____
Refills: _____ Dose instructions: _____

Anticipated date of treatment: ___/___/___ Place of Administration Name*: _____
Place of Administration Address*: _____
**If administration location differs from provider location then enter name and address here.*

I authorize AstraZeneca's Access 360 program to convey the attached prescription on my behalf to the pharmacy chosen above and to receive information on the status and related matters. By signing above, I certify that the medicine prescribed on this form is medically necessary based on my independent medical judgment, and I have received the necessary authorization to release the information included on this form and other protected health information (as defined by HIPAA) to Access 360, the dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy. Each practitioner is solely responsible for ensuring the accuracy of the information submitted.

I verify that the information provided on this form is accurate. I understand that the patient must have an FDA-approved diagnosis to be eligible for free limited supply. Reimbursement for the cost of the product administered to the above patient on the date(s) indicated has not been sought and will not be sought from any source. Additionally, I understand that AstraZeneca reserves the right to conduct periodic audits of the records, excluding patient-identifiable data (unless patient authorization is on file with AstraZeneca Access 360), of all entities receiving free limited supply. I understand that AstraZeneca reserves the right to modify or revoke this program at any time without notice. My signature confirms that this product was provided free of charge to this patient.

Prescriber Name: _____
Prescriber Signature: _____ **Date:** ___/___/___

Patient Name: _____

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SECTION 5 *AstraZeneca Patient Savings Program*

For commercially insured patients, the AstraZeneca Patients Savings Program is available for the following medications: CALQUENCE® (acalabrutinib) IMFINZI® (durvalumab) FASLODEX® (fulvestrant) IRESSA® (gefitinib) TAGRISSO® (osimertinib) LYNPARZA® (olaparib).

Use this form to enroll patients to the IRESSA® (gefitinib) TAGRISSO® (osimertinib) or LYNPARZA® (olaparib) AstraZeneca Patient Savings Program. Alternatively, you can enroll and view patients online via the Patient Savings Program enrollment portal at: ***www.AstraZenecaSpecialtySavings.com***

IMPORTANT: This form cannot be used to enroll patients into the IMFINZI® (durvalumab) or FASLODEX® (fulvestrant) Patient Savings Program; patients must be enrolled into those programs via the enrollment portal.

When using the enrollment portal, at the completion of the enrollment process you will receive patient-specific account information available for immediate use. In addition, you can log in at any time to review program utilization and remaining balance information. This information will not be available if you enroll the patient using this form.

Answer the following questions to certify compliance with the terms and conditions of the program:

1. I certify that I have received any appropriate authorization to proceed with the enrollment of this patient: ☐ I Agree
2. Is the patient on commercial (also known as private) Insurance? ☐ Yes ☐ No
3. Are the patient's prescriptions paid for in part or in full under any federally funded programs? ☐ Yes ☐ No
4. Is the patient a current resident of one of the 50 United States or Puerto Rico? ☐ Yes ☐ No
5. I have any appropriate authorization to share patient information disclosed during this enrollment, including name, Email address, mailing address, and phone number, with AstraZeneca, the sponsor of the card, as well as parties working on behalf of AstraZeneca. The information shared will include the date that the patient filled the prescription, specifics about the medication dispensed by the pharmacist, and out-of-pocket costs: ☐ Yes ☐ No
6. Required information **if not already indicated on this enrollment form**:

   Practice Name: _____ Phone #: _____ Fax: _____

   Practice Address Street: _____

   City: _____ State: _____ ZIP: _____

   Practice Tax ID: _____ Practice NPI: _____

Provider Signature: _____ **Date:** ____/____/____

AstraZeneca