




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:

- | | | |
|---|--|--|
| <input type="checkbox"/> CALQUENCE® (acalabrutinib) | <input type="checkbox"/> FASLODEX® (fulvestrant) | <input type="checkbox"/> IMFINZI® (durvalumab) |
| <input type="checkbox"/> IRESSA® (gefitinib) | <input type="checkbox"/> LYNPARZA® (olaparib) | <input type="checkbox"/> TAGRISSO® (osimertinib) |

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

- | | |
|---|---------------------|
| <input type="checkbox"/> Access 360 Patient Authorization | SECTION 1 |
| <input type="checkbox"/> Benefits Investigation | SECTION 1, 2 & 3 |
| <input type="checkbox"/> Prior Authorization | SECTION 1, 2 & 3 |
| <input type="checkbox"/> Claims and Appeal Support | SECTION 1, 2 & 3 |
| <input type="checkbox"/> Pharmacy Coordination | SECTION 1, 2, 3 & 4 |
| <input type="checkbox"/> Affordability Support (AstraZeneca Patient Savings Program) | SECTION 1, 2, 3 & 5 |
| <input type="checkbox"/> Free Limited Supply | SECTION 1, 2, 3 & 4 |
| <input type="checkbox"/> Access 360 Portal (also available at www.MyAccess360Portal.com) | SECTION 3 |

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

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



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

SECTION 3 Provider Information

Provider Information

Diagnosis Code:

	Provider Practice	Treatment Practice* <small>*Optional if patient is referred to another place of administration</small>
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:** / /

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:** ____ / ____ / ____



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:** ____ / ____ / ____

