AstraZeneca Access 360™ Enrollment Form

CALQUENCE® (acalabrutinib) 100 mg capsules | AstraZeneca Access 360™

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

About This Form: Use this form to enroll in Access 360. Once completed and signed, fax the form to **1-844-329-2360**. You may need to provide additional information depending on the type of support requested.

Services Requested: Unless indicated below, Access 360 will perform our standard support services, including Benefit Investigation, Affordability, Prior Authorization, Appeal Support, and Pharmacy Submission. If you would like us to perform a specific service, please indicate it here: ☐ Other _____

1 Patient Information

First Name: _____ Last Name: _____ Patient DOB: ___/___/_____

Gender: ☐ Female ☐ Male Patient preferred language (if other than English): _____

Street: _____ City: _____ State: _____ ZIP: _____

Patient Phone #: _____ Mobile Phone #: _____ Patient Email: _____

Alternate Contact Name: _____ Relationship to Patient: _____ Alternate Contact Phone #: _____

Okay to contact patient? ☐ Yes ☐ No Okay to leave a voicemail? ☐ Yes ☐ No

Insurance Information

Pharmacy Insurance Provider: _____ Pharmacy Insurance Phone #: _____

Cardholder Name (if not the patient): _____ DOB: ___/___/_____

Group #: _____ Policy #: _____ BIN/PCN #: _____

Medical Insurance Provider: _____ Medical Insurance Phone #: _____

Cardholder Name (if not the patient): _____ DOB: ___/___/_____

Group #: _____ Policy #: _____ BIN/PCN #: _____

NOTE: If patient has more than one insurance plan, please provide copies of the front and back of both their primary and secondary insurance cards.

Insurance Card

☐ Copy of primary medical card ☐ Copy of secondary medical card ☐ Copy of pharmacy card ☐ No insurance

2 Provider Information

Prescriber Name: _____ Specialty: _____

Practice Name: _____ Office Contact Name: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone # 1: _____ Phone # 2: _____ Fax #: _____ Email: _____

Prescriber NPI #: _____ Tax ID #: _____

Alternate Office Contact Name: _____ Alternate Office Contact Phone #: _____ Alternate Office Contact Email: _____

I authorize Access 360 program to convey the attached prescription on my behalf to the pharmacy chosen below and to receive information on the status and related matters. By signing below, 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 or assisting in initiating or continuing therapy. Each practitioner is solely responsible for ensuring the accuracy of the information submitted.

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 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 Access 360 to contact the patient, if not included with this submission, to obtain a signed Access 360 Patient Authorization Form.

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

3 Prescription and Clinical Information

Diagnosis

ICD-10 code: _____ Description: _____

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.*

CALQUENCE® (acalabrutinib) 100-mg capsules Quantity: _____ Refills: _____

Dose instructions: _____

X _____

Prescriber Original Signature

Date: ___/___/_____

Optional prescription (15-day supply) for eligible patients to support access to prescribed treatment if there is a delay in determining whether prescription coverage is available.

CALQUENCE® (acalabrutinib) 100-mg capsules Quantity: _____

Dose instructions: _____

X _____

Prescriber Original Signature

Date: ___/___/_____

Once completed and signed, fax this form to 1-844-329-2360. You may need to provide additional information depending on the type of support requested.

4 Patient Authorization

Patient Information

First Name: _____ Last Name: _____ DOB: ___/___/___

Street: _____ City: _____ State: _____ ZIP: _____

Home Phone #: _____ Mobile Phone #: _____

Email: _____

I authorize my health care providers (HCPs) and staff, my health plan, and my pharmacies to use and share Protected Health Information (my "Information") with 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, demographic, contact, and any other Information bearing on my health. My Information may be used to verify treatment and payment decisions with my HCPs; investigate and assist with coordination of coverage for AstraZeneca products; coordinate prescription fulfillment and financial assistance; and perform internal analysis at AstraZeneca to better meet patient needs. I understand and agree that AstraZeneca may contact me by mail, email, and telephone. 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 calling 1-844-ASK-A360. 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. This authorization expires two (2) years from the date signed below, unless a shorter period is required by state law.

Which best describes you? ☐ I am a patient ☐ I am a legally authorized representative

Patient Name/Legally Authorized Representative Name

_____

Signature of Patient/Legally Authorized Representative

_____ **Date:** ___/___/___

☐ By checking the box, you will receive information about your disease and may receive information about other AstraZeneca medicines and services related to your condition. *(Optional)*

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 health care 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 you want to report a medication side effect, please call 1-800-236-9933. Please visit www.azprivacynotice.com to review our Privacy Notice.

Once completed and signed, fax this form to 1-844-329-2360. You may need to provide additional information depending on the type of support requested.

1-844-ASK-A360 (1-844-275-2360) **1-844-FAX-A360** (1-844-329-2360) **www.MyAccess360.com**

Access360@AstraZeneca.com **One MedImmune Way,** Gaithersburg, MD 20878