

# How to complete an Access 360 enrollment form for infused medications

Medication

## AstraZeneca Access 360™ Enrollment Form

**Services Requested** (check only those that apply)

Benefit Investigation and Prior Authorization Support

Co-Pay Support (Note: You may also visit [www.astrazenecaspecialtyavings.com](http://www.astrazenecaspecialtyavings.com) for direct enrollment into the Product X Patient Savings Program)

Pharmacy Coordination

Claims/Billing Support (Please attach a copy of the claim submitted and Explanation of Benefits)

Appeals Support (Please attach a copy of the denial letter)

Please complete form, sign, and fax all pages to **1-844-329-2360**.

For questions or assistance, please call Access 360, Monday through Friday, 8 AM – 8 PM at **1-844-275-2360**.

To enroll in AZ&Me™ (Patient Assistance Program), visit [www.azandmeapp.com](http://www.azandmeapp.com). (Eligibility rules apply)

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### 1 Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Preferred Phone #:  Home  Mobile \_\_\_\_\_ Patient Email: \_\_\_\_\_

Alternate Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Alternate Contact Phone #: \_\_\_\_\_ Patient preferred language (if other than English): \_\_\_\_\_

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

**Patient Authorization**

I have read and agree to the Patient Authorization included on page 2

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature/Legal Representative MM DD YYYY

Printed Name/Relationship to Patient (if applicable)

**Support Programs (Savings Program and Additional Services)**

I have read and agree to the Patient Authorization included on page 2

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature/Legal Representative MM DD YYYY

Printed Name/Relationship to Patient (if applicable)

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### 2 Insurance Information

Please include front and back copies of all medical and pharmacy cards or complete this section.

Commercial/Private Insurance  Medicare/Medicaid/Tricare  No insurance

|                                      | Primary Medical Insurance | Secondary Medical Insurance | Pharmacy Insurance |
|--------------------------------------|---------------------------|-----------------------------|--------------------|
| Insurance Provider                   |                           |                             |                    |
| Insurance Phone #                    |                           |                             |                    |
| Cardholder Name (if not the patient) |                           |                             |                    |
| Cardholder DOB                       |                           |                             |                    |
| Policy #                             |                           |                             |                    |
| Group #                              |                           |                             |                    |
| BIN/PCN                              | X                         | X                           |                    |

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### 3 Provider Information

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

Prescriber NPI #: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

PTAN: \_\_\_\_\_ Other Provider ID (if applicable): \_\_\_\_\_ Alternate Office Contact Name: \_\_\_\_\_

Alternate Office Contact Phone #: \_\_\_\_\_ Alternate Office Contact Email: \_\_\_\_\_

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### 4 Clinical Information

**Diagnosis** ICD-10 code(s): \_\_\_\_\_

Description: \_\_\_\_\_

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.

HCP Name: \_\_\_\_\_

HCP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete form, sign, and fax all pages to **1-844-329-2360**. 1

## SERVICES REQUESTED

This section of the infused product enrollment forms allows you to select the type of service Access 360 conducts. Choose from:

- Benefit Investigation, Prior Authorization Support, Co-Pay Support, and Pharmacy Coordination
- Claims/Billing Support
- Appeals Support

## PATIENT SIGNATURE

**NEW!** This section is for the patient to complete in the office, and can expedite the Access 360 process. The first signature authorizes Access 360 to conduct the selected services. The second signature allows Access 360 to enroll the patient in the co-pay savings program and send treatment information.

## PROVIDER INFORMATION

The phone number, fax number, and email can refer directly to the office contact's information. Providing this information may help facilitate communications with Access 360.

## HCP SIGNATURE

This section now allows for any authorized HCP to sign the Access 360 enrollment form. This includes:

- Prescribing physicians
- Office staff
- Practice managers

## How to complete an Access 360 enrollment form for infused medications (cont'd)

Medication



### AstraZeneca Access 360™ Enrollment Form

#### Patient Authorization

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 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, 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 or by mailing a letter requesting such cancellation to Access 360 at 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. This authorization expires two (2) years from the date signed on page 1, unless a shorter period is required by state law.

#### Support Programs

##### PRODUCT X Savings Program

The Product X Savings Program is designed to facilitate your access to Product X. By providing your authorization, you allow your health care providers, insurance companies and pharmacies to use and share your health care information with the Product X Savings Program so that you can participate in this savings program. Your health information may be seen by AstraZeneca and companies working on its behalf for this savings program.

##### Additional Services

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](http://www.azprivacynotice.com) to review our Privacy Notice.

Please complete form, sign, and fax all pages to 1-844-329-2360.

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#### PATIENT AUTHORIZATION AND SUPPORT PROGRAMS (PAGE 2)

This page outlines the authorization of the patient to release specific personal information to Access 360 and explains available support options for covering the cost of their medication, if necessary.

# How to complete an Access 360 enrollment form for infused medications (cont'd)

Medication

## AstraZeneca Access 360™ Enrollment Form

Patient First Name: \_\_\_\_\_  
 Patient Last Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

**This page is only required for Pharmacy Coordination and Free Limited Supply (FLS) Request. If you are requesting Benefits Investigation, Prior Authorization Support, or Appeals Support, you only need to complete page 1.**

**5 Alternate Site of Care**  
 If administering practice differs from provider practice, then complete this section with administering practice information:

Practice Name: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Site Tax ID: \_\_\_\_\_ NPI#: \_\_\_\_\_  
 Place of Service Code: \_\_\_\_\_ Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**6 Prescription Information**  Buy and Bill (prescription information does not need to be completed)  
**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. By choosing "No Preference," the SPP will be chosen based on the results of a Benefit Investigation.

|   |  |
|---|--|
| <p><b>Product X</b></p> <p>Quantity: _____</p> <p>Quantity: _____</p> <p>Refills: _____</p> | <p><b>Free Limited Supply (FLS) Request</b><br/> <small>Free Limited Supply is available for eligible patients who face a delay in approval by their insurance company for Product X</small></p> <p><b>Product X</b></p> <p>Quantity: _____</p> <p>Quantity: _____</p> |
|---|--|

I authorize 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 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.

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. I also understand I must submit a prescription compliant with my state law. 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 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. (Using signature stamp or signing on behalf of the prescriber is not permitted.)

Prescriber Name: \_\_\_\_\_  
 Prescriber 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.

**1-844-ASK-A360** (1-844-275-2360)   
 **1-844-FAX-A360** (1-844-329-2360)   
 [www.MyAccess360.com](http://www.MyAccess360.com)  
[Access360@AstraZeneca.com](mailto:Access360@AstraZeneca.com)   
 **One MedImmune Way, Gaithersburg, MD 20878**

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**ALTERNATE SITE OF CARE**  
 This section is required for infused products if the administering practice is different from the provider practice.

**PRESCRIPTION INFORMATION**  
 This section requires you to provide detailed information about the prescription, such as product dose.  
 This section may also include information regarding the **Free Limited Supply (FLS) Request**, which applies to select AstraZeneca medications. If applicable, filling out this section can provide patients with their medication in a timely manner if the insurance company delays an approval.

**PRESCRIBER SIGNATURE**  
 This section must be signed by the prescriber if this form is being used to fill a prescription. For faxing purposes, this page can be detached from the form.

Contact AstraZeneca Access 360™ to learn more, Monday to Friday, 8 AM to 8 PM ET

**1-844-ASK-A360**  
 (1-844-275-2360)   
 **1-844-FAX-A360**  
 (1-844-329-2360)

**Access360@AstraZeneca.com**  
**www.MyAccess360.com**  
**One MedImmune Way, Gaithersburg, MD 20878**