AstraZeneca Access 360™ Enrollment Form

TAGRISSO® osimertinib | AstraZeneca Access 360™

Services Requested (check only those that apply)

- ☐ Benefit Investigation, Prior Authorization Support, and Pharmacy Coordination (Please check "On-Site Dispense" in Section 5 if the prescription will be filled at an in-office pharmacy.)
  - ☐ Co-Pay Support (Note: You may also visit www.tagrissosavings.com for direct enrollment into the TAGRISSO Patient Savings Program)
- ☐ Appeals Support (Please attach a copy of the denial letter)

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

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**.

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)

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

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

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: _____

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

TAGRISSO Savings Program

The TAGRISSO Savings Program is designed to facilitate your access to TAGRISSO. By providing your authorization, you allow your health care providers, insurance companies and pharmacies to use and share your health care information with the TAGRISSO 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 to review our Privacy Notice.

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Patient First Name: _____

Patient Last Name: _____ Patient DOB: ____/____/____

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: _____

4 Clinical Information

Diagnosis ICD-10 code(s): _____

Description: _____

5 Prescription Information

☐ On-Site Dispense (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.*

TAGRISSO® (osimertinib)

80-mg tablets Quantity: _____

Refills: _____

Dose adjustment

40-mg tablets Quantity: _____

Refills: _____

Dose instructions: _____

Free Limited Supply (FLS) Request

Free Limited Supply is available for eligible patients who face a delay in approval by their insurance company for TAGRISSO

TAGRISSO® (osimertinib)

80-mg tablets Quantity: _____

Dose adjustment

40-mg tablets Quantity: _____

Dose instructions: _____

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.

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**

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

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