AstraZeneca Access 360™ Intake Form

Access 360™ | BAXFENDY™ baxdrostat

Services Requested (check only those that apply)

- ☐ **Benefit Investigation**
- ☐ **Prior Authorization:**
  - ☐ Research ☐ Follow-Up
- ☐ **Claims/Authorization Appeal Support**
- ☐ ***Optional: Free Limited Supply (FLS) Request***

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

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 – 6 PM at **1-844-275-2360**.

1 Patient Information

Name (First, Last):			Patient Contact Number:	
DOB: / /	Gender: ☐ Male ☐ Female		Home Phone: ☐ Mobile Phone: ☐	
Primary Language: ☐ English ☐ Spanish ☐ Other:			Patient Email Address:	
Street Address:			Communication Preference: ☐ Email ☐ Text ☐ Both*	
City:			Relationship to Patient:	1) 2)
State:	ZIP:		Alternate Contact Phone #:	1) 2)

Patient Authorization

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

_____ ____/____/_____

Signature of Patient or Legal Representative — Today's Date

_____ _____

Printed Name — Relationship to Patient

2 Insurance Information

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

☐ No insurance

	Pharmacy Benefit
Insurance Provider Name	
Insurance Phone #	
Cardholder Name (if not the patient)	
Cardholder DOB	
Policy #/Patient ID #	
Group #	
BIN/PCN	

3 Prescriber Information

Prescriber Name:		Practice Name:	
Prescriber Specialty:		Street Address:	
Office Contact Name:		City:	
Phone #:	Fax #:	State:	ZIP:
Email:		Prescriber NPI #:	
Alternate Office Contact Name:		Tax ID #:	
Alternate Contact Phone #:			
Alternate Contact Email:			

4 Clinical Information

Diagnosis ICD-10-CM 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 form.

HCP Name

_____

HCP Signature

_____ **Date:** ____/____/_____

AstraZeneca Access 360™ Intake Form (Continued)

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 AstraZeneca Access 360™) and its affiliates, as well as its contractors ("AstraZeneca"), and my pharmacies may receive payment from AstraZeneca in exchange for sharing my Information and/or providing support services, which may be considered marketing pursuant to this Authorization. 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; coordinate educational nursing support; and perform internal analysis at AstraZeneca to better meet patient needs. I understand and agree that AstraZeneca may contact me by mail, email, telephone, and text. 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 AstraZeneca Access 360™ support. I understand that I may request a copy of or cancel this Authorization at any time by calling 1-800-236-9933 or by mailing a letter requesting such cancellation to AstraZeneca 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, unless a shorter period is required by state law.

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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