AstraZeneca Access 360™ Enrollment Form

Fasenra (benralizumab) | AstraZeneca Access 360

Please complete form, sign, and fax all pages to **1-833-329-2360**. For questions or assistance, please call Access 360, Monday - Friday, 8 AM – 8 PM ET at **1-833-360-4357**.

Services Requested (check all that apply)

Patient Initiation Services:

- ☐ **Benefit Investigation with Prior Authorization Research** (Access 360 will research both the pharmacy and medical benefit for your patient, including prior authorization requirements and specialty pharmacy)
- ☐ **Pharmacy Research and Triage** (Access 360 will determine the specialty pharmacy for the patient and submit the referral. Please note, this is not applicable to Buy & Bill)
- ☐ **Prior Authorization Follow-up with Appeals Support*** (Access 360 will contact the payer to track the status of the patient's prior authorization)

*Can only complete if patient signs Patient Authorization below.

Additional Services:

☐ Claims & Billing Support ☐ Appeals Support

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

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): ______ OK to contact patient? ☐ Yes ☐ No

OK to leave a detailed voicemail? ☐ Yes ☐ No Has the patient received the Patient Welcome Kit? ☐ Yes ☐ No Communication Preference (choose one): ☐ Email ☐ Text ☐ Both

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)

FASENRA 360 Support Program (Savings Program and Additional Services)

I have read and agree to the Support Programs 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

	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	

3 Provider Information

Prescriber Name: ______ Specialty: ______

Practice Name: ______ Phone #: ______ Fax #: ______

Street: ______ City: ______ State: ______ ZIP: ______

Authorized HCP Office Staff Name: ______ Authorized HCP Office Staff Phone: ______

Authorized HCP Office Staff Email: ______ Prescriber NPI #: ______ Tax ID #: ______

Medicare Provider # (PTAN): ______ Group NPI #: ______ Other Payer-specific Provider #: ______

By signing this form, I certify that (1) I have received the necessary authorization 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.

Authorized HCP Office Staff Name: ______

Authorized HCP Office Staff 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 1-833-360-HELP 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.

FASENRA 360 Support Program

FASENRA Savings Program

The FASENRA Savings Program is designed to facilitate your access to FASENRA. By providing your authorization, you allow your health care providers, insurance companies and pharmacies to use and share your health care information with the FASENRA 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 which includes, but is not limited to, providing me with educational and promotional materials, services related to my medical condition or therapy such as injection support for self-administration and for market research purposes which includes contacting me to participate in focus groups, surveys or interviews. This may include AstraZeneca or a third party working on AstraZeneca's behalf contacting me by telephone, email and/or text message regarding AstraZeneca support programs that may be of interest to me. My Information may also be used to perform internal analysis at AstraZeneca. Information provided by AstraZeneca does not take the place of talking to your health care provider about your treatment or condition.

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. I understand that I may cancel this Authorization at any time by calling 1-833-360-HELP or by mailing a letter requesting such cancellation to Access 360 at One MedImmune Way, Gaithersburg, MD 20878.

I consent to receive marketing and non-marketing calls and texts from and on behalf of AstraZeneca and AstraZeneca's Access 360, made with an autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Message and data rates may apply. Text STOP to opt out and HELP for help.

AstraZeneca or third parties working on its behalf will not sell or rent your personal information. Please visit www.globalprivacy.astrazeneca.com to review our Privacy Notice.

AstraZeneca Access 360™ Enrollment Form

Fasenra (benralizumab) | AstraZeneca Access 360

Patient First Name: ______________________ Patient Last Name: ______________________ Patient DOB: ____/____/____

4 Clinical Information

Diagnosis ICD-10 Code:
☐ J45.50 Severe persistent asthma, uncomplicated
☐ J45.51 Severe persistent asthma with (acute) exacerbation
☐ Other ______________________

Eosinophil Count: __________ cells/μL Date of Test: ____/____/____

Number of asthma exacerbations (requiring use of systemic corticosteroids and/or hospitalization) in the last 12 months: __________

5 Acquisition Information

Administration Method (choose one): ☐ Pre-Filled Syringe (Office-Administered) ☐ Pen (Self-Administered) ☐ Would like to understand coverage for both administration methods

☐ In-network Specialty Pharmacy Provider (SPP)* (Preferred SPP: ______________________)

*If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-833-360-4357.

☐ Buy & Bill (prescription information does not need to be completed, research Buy & Bill only)

☐ I am unsure/undecided how I will obtain FASENRA (Access 360 will research both SPP and Buy & Bill options)

Place of Administration (choose one): ☐ Prescribing Office (Pre-Filled Syringe) ☐ Patient Home (Pen) ☐ Alternate Site of Care (ASOC)† (Pre-Filled Syringe)

Alternate Site of Care (ASOC) Information *ONLY complete this section if the place of administration differs from the prescribing office.*

Administering Practice/Facility: ______________________ Administering Physician Name: ______________________

Phone #: ______________________ Fax #: ______________________ Site Tax ID: ______________________

NPI #: ______________ Street: ______________________ City: ______________________ State: ________ ZIP: ________

Medicare Provider # (PTAN): ______________________ Other Payer-specific Provider #: ______________________

†An ASOC is a place of administration that differs from the prescribing office. Alternate sites of care include a Hospital-based Outpatient Department (HOPD), an Alternate Injection Center (AIC), or a physician's office that differs from the prescribing office. Access 360 **will not triage** or communicate benefit investigation results or script to the ASOC listed. Access 360 **will only** confirm that the ASOC is in-network.

6 Prescription Information

Rx FASENRA® (benralizumab)

What is your **primary** choice?

☐ FASENRA® (benralizumab) 30 mg/mL single-dose prefilled syringe Office-Administered (10-digit NDC: 0310-1730-30)

☐ FASENRA Pen™ (benralizumab) 30 mg/mL single-dose autoinjector Self-Administered (10-digit NDC: 0310-1830-30)

☐ Please send alcohol wipe and sterile gauze to patient

Has this patient started therapy? ☐ Yes ☐ No

If yes, how many doses has the patient received? ______________

☐ **Loading Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 4 weeks for 3 doses**

Quantity: 1 Refills: __________

☐ **Maintenance Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 8 weeks**

Quantity: 1 Refills: __________

Known Allergies: ______________________

Last Injection Date: ____/____/____

If primary choice is not covered, what is your **secondary** choice?

☐ FASENRA® (benralizumab) 30 mg/mL single-dose prefilled syringe Office-Administered (10-digit NDC: 0310-1730-30)

☐ FASENRA Pen™ (benralizumab) 30 mg/mL single-dose autoinjector Self-Administered (10-digit NDC: 0310-1830-30)

☐ Please send alcohol wipe and sterile gauze to patient

☐ 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 FASENRA.

FASENRA® (benralizumab)

Quantity: 1

Dose Instructions: ______________________

Please read Prescriber Authorization on Page 4 before signing.

Prescriber Name: ______________________ **NPI #:** ______________ **State License #:** ______________

Prescriber Signature: Dispense as written ______________________ **Date:** ____/____/____

Prescriber Signature: Substitution permitted ______________________ **Date:** ____/____/____

Once completed and signed, fax this form to **1-833-329-2360**. You may need to provide additional information depending on the type of support requested.

Prescriber Authorization

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 on Page 3, 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 a diagnosis consistent with an FDA-approved indication for FASENRA 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).

1-833-360-HELP (1-833-360-4357)

1-833-FAX-A360 (1-833-329-2360)

www.FasenraResources.com

Access360@AstraZeneca.com

One MedImmune Way, Gaithersburg, MD 20878

FASENRA is a registered trademark and AstraZeneca Access 360, AZ&Me, and FASENRA Pen are trademarks of the AstraZeneca group of

Application for Free AstraZeneca Medicines

Specialty Care Products (Oncology & Respiratory Biologics)

PATIENT INFORMATION:

*Please print clearly in **blue or black** ink. Asterisks indicate required fields.*

Primary language spoken: ☐ English ☐ Spanish ☐ Other:________________

☐ New Application ☐ Re-enrollment

Patient Name*:____
First *Middle Initial* *Last*

Date of Birth*: ____/____/_____ *(MM/DD/YYYY)*

Address*: ____________________ City*:____________ State*: ________ Zip*:________

☐ Patient has no current address. (Medication will be shipped to HCP's office) PLEASE NOTE: Medications cannot be shipped to Post Office (PO) boxes.

Phone*: (_____) ____________ Mobile Phone: (_____)____________ E-mail: ________________

PRESCRIBER INFORMATION: This form will replace all previous prescriptions that may have been sent.

Please complete prescription in its entirety.

Prescriber Name*: ____________________ Phone*: (_____) ________ Fax*: (_____) __________

Address*: ____________________ City*:____________ State*:________ Zip*:________

Prescriber E-mail: ____________________ NPI*:____________ State License Number (SLN):__________

Office Contact Name*: ____________ Phone*: (_____)________ Practice Name*: ________________

☐ Syringe ☐ Pen ☐ Vial ☐ Oral ☐ Other

Please list medication(s):

Medication*:	Strength*:	Directions*:	Quantity*:	Refills*:

SHIP MEDICATION TO: ☐ PATIENT ☐ PRESCRIBER†

(†For Prescribers in Ohio ONLY: Pursuant to OAC 4729-5-10, Ohio prescribers must be approved by the Ohio Board of Pharmacy to be a pick-up station)

Prescriber Signature: ____________________________ ***Date:***____________

NY Prescribers must attach a separate prescription in accordance with NY pharmacy law.

Program Eligibility Information: *Please print clearly in **blue or black** ink.*

INCOME:

What is the total combined household income before taxes? *(Include yourself, all adults, and all dependents)*

Income Verification: AZ&Me and its authorized third-party agents will use my date of birth and/or additional demographic information as needed to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact my credit score. AZ&Me and its authorized third-party agents reserve the right to ask for additional documents and information at any time.

$____________________ Monthly OR $____________________ Yearly

Number of people in your household: ____________ Number of dependents in your household under 18 years of age:__________
(Include yourself, all adults, and all dependents)

INSURANCE:

Do you have any form of prescription drug coverage? ☐ Yes ☐ No

If Yes, please check all that apply:

☐ Employer-furnished or commercial/private drug coverage. Please provide plan name and ID number:____________________

☐ VA or Military Benefits ☐ Other Prescription Coverage ____________

☐ Medicaid Prescription Drug Coverage

☐ Medicare Part B (medical benefit that covers some prescription medications)

☐ Medicare Part D (prescription drug coverage). Please provide payer name:________________

☐ Low Income Subsidy

If the requested medication is covered under Medicare Part B or Part D, how much have you spent on prescription medicines during the current year? $____________________

Do you have Medicare supplemental (Medigap) coverage? ☐ Yes ☐ No

If so, does your supplemental coverage cover your total out-of-pocket cost for your medication? ☐ Yes ☐ No

CONSENT:

I GIVE my doctor, AstraZeneca, and the Program administrator and their employees, agents, and contractors permission to verify my information to make sure it is true and complete; contact me by mail or phone about the Program and about other products, programs, or services that might interest me or for which I may be eligible; contact me in order to ensure that I have received the medicines sent by the Program.

I PROMISE that all the information in this application, including all copies of documents proving my income, is true and complete; I am authorized to sign this application; I do not have any assistance or insurance that would help pay for my medicines (other than Medicare, if applicable); I will contact the Program if any of my information about my prescription drug coverage or insurance changes.

I UNDERSTAND that the Program will only use my information to decide if I qualify to participate in the Program; administer or improve the Program; communicate with insurance plans, including Medicare plans; share my information with the Centers for Medicare and Medicaid Services.

I UNDERSTAND that I may be required to apply for prescription assistance through a government assistance program to maintain eligibility in the Program.

I UNDERSTAND that I can call 1-800-292-6363 at any time to withdraw from the Program and/or cancel my permission to use my information. I can visit www.globalprivacy.astrazeneca.com to review AstraZeneca's Privacy Notice.

I UNDERSTAND that the Program can request more information from me at any time; AstraZeneca can change or stop the Program at any time or for any reason.

I UNDERSTAND that once my information has been disclosed to my doctor, federal privacy laws may no longer restrict its use or disclosure, but the Program will only use my information as described in this form.

I MAY refuse to sign this authorization form and if I refuse, my eligibility for health plan benefits and treatment by my healthcare provider will not change, but I will not have access to the Program.

I GIVE the Program, and the Program administrators, permission to contact the person named below with follow-up questions about my application (this only applies if someone completed this application for you).

This authorization form will be effective for 1 year unless it expires earlier by law or I cancel it in writing. I have a right to receive a copy of this form after I have signed it.

Signature of Applicant or Parent/Legally Authorized Representative. *If patient is a minor, parent or legally authorized representative should sign here.*

Relation to Patient: ☐ Patient ☐ Parent/Legally Authorized Representative of Patient

X______________________________ **Date:**_____/_____/______(MM/DD/YYYY)

If someone helped you with this application and you want them to answer questions for you, please give us their name and phone number:

*Helper's Name:*______________________________ *Helper's Phone: (____)* __________

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Questions? Call **1-800-292-6363**
Monday–Friday, 9:00 AM to 6:00 PM ET
or visit **www.azandmeapp.com**