AZ&ME Application for Free AstraZeneca Medicines

AZ&ME
AstraZeneca Prescription Savings Program

PATIENT APPLICATION [*(Form AZMEAPPv1p1)*] **APPLICATION TYPE:** ◯ New ◯ Re-enroll

① Please complete form in **Blue** or **Black** ink with readable letters and fill in circles completely. Once completed, **sign and fax to 1-877-239-0867 with AZ&ME Provider Form**. Both forms must be received to determine eligibility. For questions or assistance, please call AZ&Me, Monday–Friday, 9 AM–6 PM ET at 1-800-292-6363.

② **PATIENT (PT) INFORMATION** (AZ&ME is available only to US residents, citizenship is not required)

PT Date of Birth: MM – DD – YYYY **Gender at Birth:** ◯ Male ◯ Female

PT First Name: _____ **PT Last Name:** _____

PT Address: _____ **PT Apt No.**_____

PT City: _____ **PT State:** __ __ **PT Zip:** _____

PT Phone: _____ – _____ **PT Phone type?** ◯ Mobile ◯ Home

PT Email: _____

Preferred Language ◯ English ◯ Spanish ◯ Other **Communication Preference** ◯ Text ◯ Email ◯ Postal Mail

③ **Designated Contact (DC)** (Able to act on behalf of Patient for Program actions other than authorization)

DC First Name: _____ **DC Last Name:** _____

DC Phone: _____ – _____ **DC Phone type?** ◯ Mobile ◯ Home

④ **Income Information**

Annual Gross Household Income: $__ __ __, __ __ __ **Household Size (including patient):** __ __

⑤ **Insurance Information**

Do you have health insurance? ◯ Yes ◯ No (skip to step 6)

Insurance Type (select all that apply)*

◯ Medicare – Medicare Beneficiary Identifier (MBI) is Required: __ __ __ __ __ __ __ __ __ __ __

◯ Other Government-Sponsored Programs (Medicaid, SCHIP, TRICARE, VHA, IHS)

◯ Commercial/ Private

** For insurance types other than Medicare, please attach evidence of product(s) not covered or exhaustion of benefits for product(s) in order to be considered for Program eligibility.*

⑥ **Patient Authorization–Which best describes you?**

◯ **Patient** ◯ **Legally Authorized Representative (LAR)**–*Complete LAR information below*

LAR First Name: _____ LAR Last Name: _____

LAR Relation: _____ LAR Date of Birth: MM – DD – YYYY

LAR Phone: _____ – _____ LAR Phone type? ◯ Mobile ◯ Home

LAR Email: _____

I have read and agree to the AZ&ME Prescription Savings Program Patient Authorization on Page 2.

Signature of Patient/Legally Authorized Representative **Today's Date:** MM – DD – YYYY

SIGN HERE

To obtain a copy of the Prescribing Information for AstraZeneca products, please go to:
https://www.astrazeneca-us.com/medicines/astrazeneca-medications.html

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AZ&ME APPLICATION- PATIENT AUTHORIZATION (Page 2)

I authorize my health care providers (HCPs) and staff, my health plans, and my designated contact to use, share and verify my Protected Health Information (my "Information") with AstraZeneca, including the AZ&ME Prescription Savings Program ("Program") and its affiliates, as well as its contractors ("AstraZeneca"). My Information includes my prescription-related health records, health care plan benefits, demographic, contact, and any other Information bearing on my health. My Information may be used to determine Program eligibility, administer and improve the Program, verify Program participation with health plans, including Medicare and transition support to another manufacturer, when applicable.

All information I provide to AstraZeneca is true and complete. I am authorized to sign any documents related to this Program. I will contact the Program if any of my Information changes. Applicants may be required to apply for applicable government assistance programs to maintain eligibility in the Program. AstraZeneca can change or stop the Program at any time.

I understand the Program will use my Information to access my credit information and other sources to estimate my household income for Program eligibility. As a soft credit inquiry, this option will not impact my credit score.

I understand and agree that AstraZeneca may contact me by mail, email, telephone, and text based on my provided communication methods, which may be made with an auto-dialer or prerecorded voice. Message and data rates may apply.

I understand that federal privacy laws may not protect my Information once it is disclosed; however, AstraZeneca agrees to protect my Information by using/disclosing it only for purposes specified.

I understand that I can refuse to sign this Authorization and that this will not affect 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 understand that I may cancel this Authorization at any time by calling 1-800-292-6363 or by mailing a letter requesting such cancellation to AZ&ME 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. Please visit www.globalprivacy.astrazeneca.com to review our Privacy Notice.

This authorization expires two (2) years from the date signed, unless a shorter period is required by state law.

AZ&ME Provider Form

AZ&ME
AstraZeneca Prescription Savings Program

① HEALTHCARE PROVIDER (HCP) SHOULD COMPLETE THIS FORM *(Form AZMERXv1p1_22)*
Please complete form in **Blue** or **Black** ink with readable letters and fill in circles completely. Once completed, **sign and fax to 1-877-239-0867** from the HCP's Office.

HCP will not seek reimbursement or credit from products provided as part of this program from insurers or government programs. HCP attests that products requested are medically necessary for patient.

② PRESCRIBER INFORMATION **Facility NPI:** 1629301163

Facility Name: Missouri Heart Center

HCP First Name: _____ **HCP Last Name:** _____

HCP NPI: _____ **State License Number:** _____

Contact Information (no PO Boxes)

Address: 1605 E Broadway **Suite No.** 300

City: Columbia **State:** MO **Zip:** 65201

HCP Phone: (573) 256-7700 **HCP Fax:** (573) 256-3003

③ Office Contact (OC)

OC First Name: _____ **OC Last Name:** _____

OC Phone: _____ **Extension:** _____

Email: _____

④ Prescription - This request will replace all previous prescriptions that may have been sent.

Patient First Name: _____

Patient Last Name: _____

Date of Birth: MM – DD – YYYY ◯ **New RX** **or** ◯ **Dose Change**

Product: Farxiga Tablets

Strength: ◯ 5mg **or** ◯ 10mg

Quantity: _____

Refills (enter # or Select 1yr)**:** _____ **or** ◯ 1yr

Directions for Use/ Product Specific Dosing:

Prescriber Signature (must be wet signature) **Today's Date:** MM – DD – YYYY

SIGN HERE

Ohio Prescribers: Pursuant to OAC 4729-5-10, Ohio prescribers must be approved by the Ohio Board of Pharmacy to be a pick-up station. NY Prescribers must attach a separate prescription in accordance with NY pharmacy law or ePrescribe.

Please see full Prescribing Information, including boxed WARNINGS for AstraZeneca products at:
https://www.astrazeneca-us.com/medicines/astrazeneca-medications.html

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