Application for Free AstraZeneca Medicines: **SYNAGIS® (palivizumab)**

PO Box 898, Somerville, NJ 08876

AZ&ME™
AstraZeneca Prescription Savings Program

How to Complete this Application:

1. Review the information on this page carefully and keep it for your records.
2. Complete pages 3 and 4 of the application, including parent/caregiver signature.
3. Gather the required documentation listed on page 2.
4. Mail or fax the completed application and required documentation following the instructions on the next page.

What are the AZ&Me Prescription Savings Programs?

- The AZ&Me Prescription Savings Programs (the Program) are a group of programs offered by AstraZeneca that allow your patients to get free medicines if they qualify. It is neither a government program nor an insurance plan
- Patients who qualify may receive free AstraZeneca medicines for up to 1 year

The Program can be changed or stopped by AstraZeneca at any time or for any reason.

Does your patient qualify for the Program?

Patients may qualify for the Program if:

✓ They are a US Citizen, or a Green Card or Work Visa holder

✓ The patient's household meets certain income limits

✓ **And one** of the following applies:

- ☐ The patient does not have prescription drug coverage that helps pay for SYNAGIS
- ☐ The patient has insurance coverage but has had an appeal for SYNAGIS coverage denied by their insurance company

The Affordable Care Act has created a marketplace of Health Insurance Exchanges where uninsured individuals and families are able to purchase healthcare coverage, the cost of which may be subsidized for qualified enrollees. More information about these plans can be found at www.healthcare.gov.

Please review the checklist on the next page to ensure that your application is complete and ready for submission.

AZ&ME™
AstraZeneca Prescription Savings Program

AZ&Me Prescription Savings Program Application Checklist

The following items must be submitted by mail or by fax to complete your application, even if you have completed the application online. Keep this page for your records.

Send ALL the following TOGETHER:

- ☐ A completed application, signed and dated by parent/caregiver
- ☐ Copy of insurance card (for insured patients only)
- ☐ Proof of household income (include only **one** of the following):
  - A copy of last year's federal income tax returns for yourself, spouse, and dependents
  - All income statements from jobs last year (W-2 or 1099)
  - A paystub dated within the last 3 months
  - Current Social Security Income Yearly Benefits Statement
  - **If current household income is zero**, a letter explaining your financial situation from a family member, healthcare provider, or yourself
- ☐ Documentation of a denied appeal to the applicant's insurance company for SYNAGIS® (palivizumab) coverage. Please also include documentation of the submitted appeal. (Insured patients only)

Please note: SYNAGIS may be shipped for patients who appear eligible for the AZ&Me Prescription Savings Program prior to receipt of Proof of Income documents. Proof of Income and/or insurance appeal and denial documents must be provided to AZ&Me in order to be eligible for additional SYNAGIS shipments.

Please do not send your medical records or Statement of Medical Necessity form with your application.

MAIL your completed application and required proof of income documentation to:

AZ&Me Prescription Savings Program
PO Box 898
Somerville, NJ 08876

Or

Your doctor's office may FAX your completed application and required documentation, with a fax cover sheet to **855-686-8795**.

Important Information About Your Application

Information provided to us will be used to determine possible eligibility for help from another program such as Medicaid. You may be required to submit documentation supporting that you do not qualify for other prescription assistance.

Application for Free AstraZeneca Medicines
SYNAGIS® (palivizumab)

AZ&ME™
AstraZeneca Prescription Savings Program

Prescription Information

PATIENT INFORMATION: *Please print clearly in **blue or black** ink.*

Name: _____
First *Middle Initial* *Last*

Parent or Caregiver Name: _____
First *Middle Initial* *Last*

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Alternate Phone: (_____) _____ E-Mail: (_____) _____

Multiple Birth? ☐ Yes ☐ No _____ Patient Date of Birth: _____

PRESCRIBER INFORMATION:

Prescriber Name: _____ Phone: (_____) _____ Fax: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

DEA: _____ NPI: _____ State License Number (SLN): _____

Office Contact Name: _____ Phone: (_____) _____

Practice Name: _____ Office Hours: _____

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

Patient Social Security Number: _____-_____-_____

Parent/Caregiver Social Security Number: _____-_____-_____, if available ***(used for eligibility purposes only)***

Green Card Number: _____ *Work or Student Visa Number*: _____-_____-_____

INCOME:

What is the total combined household income before taxes? *(Include yourself, all adults, and all dependents)*
Note: You will need to provide proof of income with your application.

$_____Monthly OR $_____Yearly

Number of people in your household (include all adults and dependents): _____

Number of people in your household under age 18: _____

INSURANCE:

Does the patient have any form of prescription drug coverage? ☐ Yes ☐ No

If Yes, please check all that apply: ☐ Medicaid ☐ Other Prescription Coverage: _____

Name of Insurance Plan: _____ Insurance Plan Phone Number: _____

Group Number: _____ Policy Number: _____

AZ&ME™
AstraZeneca Prescription Savings Program

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 Part D, 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 Part D 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; cancel my permission to use my information and withdraw from the Program; get a copy of the AstraZeneca 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 health care 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 Parent or Caregiver

X_____**Date:**_____/_____/_____(MM/DD/YYYY)

AstraZeneca

Questions? Call 1-800-292-6363 or visit www.azandme.com

Monday - Friday 9:00 AM to 6:00 PM ET