

AZ&ME Product Shipment Request Form



① SHIPMENT REQUESTOR SHOULD COMPLETE THIS FORM (Form AZMEPSRv2p1)

Please complete form in **Blue** or **Black** ink with readable letters and fill in circles completely. Once completed, fax to **1-877-239-0867** at least 7-10 days prior to the scheduled treatment date.

If a new prescription or dose change is needed, please e-Prescribe or complete a new AZ&Me Provider Form.

② Patient First Name: _____ Patient Last Name: _____

Date of Birth: MM - DD - YYYY

Ship Product: _____ Scheduled Treatment Date: MM - DD - YYYY

Please note: Self-administered products ship directly to patients, unless an exception is requested. Office-administered products ship to healthcare providers only. By completing this form you are confirming that the recipient will be available to receive the product shipment at the specified shipping address.

③ SELF – ADMINISTERED PRODUCT: PATIENT SHIPMENT INFORMATION

PT SHIP Address: _____ PT SHIP Apt No. _____

PT SHIP City: _____ PT SHIP State: _____ PT SHIP Zip: _____

④ OFFICE – ADMINISTERED PRODUCT: HEALTHCARE PROVIDER SHIPMENT INFORMATION

☐ Prescriber OR ☐ Alternative Site of Care

SHIP NPI: _____ SHIP Facility: _____

HCP SHIP Contact: _____

HCP SHIP Address: _____ HCP SHIP Suite _____

HCP SHIP City: _____ HCP SHIP State: _____ HCP SHIP Zip: _____

⑤ **Delivery Instructions** – Allow 2-3 business days for deliveries to be scheduled. Cold Chain products ship overnight Monday - Thursday. Please indicate which days the ship to recipient is available to receive shipments:

☐ Monday (non-cold chain) ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Specific Delivery Instructions (if applicable):

Shipment tracking information is available and future shipment requests can be submitted 24/7 via the:
Self-service IVR (1-800-292-6363) or Self-service web (azandmeapp.com).

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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