AZ&Me Program Withdrawal Form

① PATIENTS WHO ARE NO LONGER IN NEED OF ASSISTANCE SHOULD COMPLETE THIS FORM TO WITHDRAWAL FROM THE AZ&ME PROGRAM *(Form AZMESRDMWF V1p1)*

- Enrolled patients (or their Legally Authorized Representative or Prescriber) must complete and sign this form to withdraw the patient from AZ&Me if they NO LONGER require assistance
- **Fax the completed form to 1-877-239-0867**.

② Patient First Name:_____ **Patient Last Name:**_____

Date of Birth: _____ **Patient AZ&Me ID:**_____

AZ&Me Withdrawal form completed by:

◯ **Patient /Legally Authorized Representative or** ◯ **Healthcare Provider**

Requestor Name: _____ **Requestor Contact Phone#:** _____

③ Withdrawal Information

◯ **The patient has obtained a grant from an Independent Charitable Assistance Foundation and no longer requires AZ&Me assistance**

◯ **The patient has obtained product coverage through their insurance**

◯ **The patient is no longer on therapy**

④ Patient/Legally Authorized Representative/Prescriber Declaration

By signing below, I attest that the information provided on this form is complete and accurate to the best of my knowledge and that the patient referenced above is no longer in need of assistance from AZ&Me. I understand that by signing this form, the patient will be withdrawn from the AZ&Me program. Should the patient require assistance from AZ&Me in the future, they will be required to submit a new AZ&Me application.

Signature of Patient/Legally Authorized Representative or Prescriber **Today's Date:**_____