# AZ&Me Application for Free AstraZeneca Medicines

AZ&ME
AstraZeneca Prescription Savings Program

**PATIENT APPLICATION** [*(Form AZMEAPPv3p2)*] **APPLICATION TYPE:** ◯ New ◯ Re-enroll

**PRODUCT(S) REQUESTED:** _____

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 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:** _____ **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

## ③ Designated Contact (DC) (Personal contact able to act on behalf of Patient for Program actions other than authorization- should NOT include healthcare providers, financial counselors or third party representatives)

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

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

## ④ Income Information

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

## ⑤ Insurance Information

Do you have health insurance? ◯ Yes (must select at least one insurance type below) ◯ No (skip to step 6)

**Insurance Type (select all that apply)**

◯ Medicare (Part B/C/D) – Medicare Beneficiary Identifier (MBI) is Required: __ __ __ __ __ __ __ __ __ __ __

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

◯ Commercial/ Private (not including Medicare Advantage/ Supplemental plans)

## 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: _____

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:** _____

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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AstraZeneca

## 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 supports the use of generic utilization wherever appropriate and may make eligibility in the program contingent on generic access. 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 do not have ANY prescription drug coverage that helps pay for or potentially helps pay for the requested medication (except for Medicare). Prescription drug coverage means any type of government health insurance program (except for Medicare) or private (commercial) insurance that may cover your medication, even if that coverage includes an alternate funding program (sometimes called specialty drug carve out) that requires you to first try to obtain your medicine from a third party or patient assistance program, like AZ&Me.

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.

**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 Provider Form

AZ&ME™
AstraZeneca Prescription Savings Program

**① HEALTHCARE PROVIDER (HCP) SHOULD COMPLETE THIS FORM** *(Form AZMERXv1p1_26)*
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:** __ __ __ __ __ __ __ __ __ __

**Facility Name:** _____

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

**HCP NPI:** _____

**Contact Information (no PO Boxes)**

**Address:** _____ **Suite No.** _____

**City:** _____ **State:** ____ **Zip:**_____

**HCP Phone:** _____ **HCP Fax:** _____

**③ OFFICE CONTACT (OC)**

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

**OC Phone:** _____ **Extension:** _____

**Email:**_____

***NEW YORK Prescribers*** *must ePrescribe or attach a separate prescription in accordance with NY pharmacy law.*

***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.*

**④ PRESCRIPTION**

**Patient First Name:** _____

**Patient Last Name:** _____

**Date of Birth:** (MM-DD-YYYY) __ __ / __ __ / _____ ◯ **Dose Change**

**Product: Lokelma Oral Suspension**

**Strength:** ◯ 5 g **or** ◯ 10 g

**Quantity:** (Rx must be written in full pack quantities, multiples of 30) _____

**Directions for Use:**
◯ Take 1 packet by mouth daily
◯ Take 1 packet by mouth every other day
◯ Take 1 packet by mouth _____ times a week
◯ Other: _____

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

**Prescriber Signature (must be wet signature)** **Today's Date:** (MM-DD-YYYY) __ __ / __ __ / _____

SIGN HERE

**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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