

AZ&Me Application for Free AstraZeneca Medicines



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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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



① HEALTHCARE PROVIDER (HCP) SHOULD COMPLETE THIS FORM (Form AZMERXv1p1_19)

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: Lynparza Tablets

Strength: ☐ 100 mg or ☐ 150 mg

Quantity: (Rx must be written in full bottle quantities, multiples of 60) _____

Directions for Use:

☐ **Standard Dose:** Take two 150 mg tablets (300 mg) by mouth twice a day

☐ **Dose Modification A:** Take one 150 mg tablet and one 100 mg tablet (250 mg) by mouth twice a day

☐ **Dose Modification B:** Take two 100 mg tablets (200 mg) by mouth twice a day

☐ 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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