PATIENT CONSENT

AZ&Me Patient Consent Form:

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, email, texting, 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 I provide to AstraZeneca is true and complete; I am authorized to sign any and all applications and forms related to this Program; I do not have any assistance or insurance that would help pay for my medicines (other than Medicare, 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 plans; share my information with the Centers for Medicare and Medicaid Services; share my information with a new patient assistance program administrator if the product I am prescribed is transferred to another manufacturer.

I UNDERSTAND that AZ&Me and its authorized third-party agents will use my date of birth and/or additional demographic information as needed to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact my credit score. AZ&Me and its authorized third-party agents reserve the right to ask for additional documents and information at any time.

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 and/or cancel my permission to use my information. I can visit www.globalprivacy.astrazeneca.com to review AstraZeneca's 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.

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Questions? Call **1-877-905-1479** Monday–Friday, 9:00 am to 6:00 pm ET
or visit **www.azandmeapp.com**
Fax: **800-961-8323**

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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 healthcare 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. *This only applies if someone completed this application for you.*

This authorization form will be effective for 2 years 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.

Patient Information (All fields are required):

First Name: _____

Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Phone Number: _____
(MM/DD/YYYY)

If patient is a minor, parent or legally authorized representative should sign here.

Relation to Patient: ☐ Patient
☐ Parent/Legally Authorized Representative of Patient

I have read both pages of this form and provide my consent:

Signature: _____ Date: _____

If someone helped you with this application and you want them to answer questions for you, please give us their name and phone number:

Helper's Name: _____ Helper's Phone: _____

How to complete this form:

Online:
Go to www.azandmeapp.com and access the electronic version of this form under the "Consent" tab.

By Fax or Mail:
Complete this form and fax/mail both pages to:
Fax: 800-961-8323
Mail: PO Box 222178, Charlotte, NC 28222

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