Application for Free AstraZeneca Medicines:

PO Box 898, Somerville, NJ 08876

AZ&ME™

AstraZeneca Prescription Savings Program

How to Complete this Application:

1. Review the information on this page carefully and keep it for your records.
2. Complete pages 3, 4 and 5 of the application.
3. Gather the required documentation listed on page 2.
4. Mail or fax your completed application and required documentation following the instructions on the next page.

What are the AZ&Me Prescription Savings Programs?

- The AZ&Me Prescription Savings Programs (the Program) are a group of programs offered by AstraZeneca that allow you to get free medicines if you qualify. It is neither a government program nor an insurance plan
- If you qualify, you may get free AstraZeneca medicine for up to 1 year, depending upon the Program in which you are enrolled. AstraZeneca will send you an application for renewal once your enrollment ends
- Your medication may be sent to your home or to your doctor's office
- Most medicines are sent in a 90-day supply

Who is AstraZeneca?

- AstraZeneca is a company that makes prescription medicines
- AstraZeneca has offered prescription savings programs to people who qualify since 1978

  The Program can be changed or stopped by AstraZeneca at any time or for any reason.

Do you qualify for the Program?

You may qualify for the Program if:

✓ You are a US Citizen, or a Green Card or Work Visa holder

✓ You meet certain household income limits
(visit **www.azandme.com** or call **1-800-AZandMe** for details)

✓ **And one** of the following applies:

- ☐ You do not have prescription drug coverage that helps pay for your AstraZeneca medicines
- ☐ You participate in Medicare Part D and have spent at least 3% of your total household income on prescription medicines through a Medicare Part D Prescription Drug Plan during the current year
- ☐ You are requesting assistance with a medication that is covered under Medicare Part B and you have spent at least 3% of your total household income on prescription medicines through your Medicare benefit during the current year

The Affordable Care Act has created a marketplace of Health Insurance Exchanges where uninsured individuals and families are able to purchase healthcare coverage, the cost of which may be subsidized for qualified enrollees. More information about these plans can be found at www.healthcare.gov.

Please review the checklist on the next page to ensure that your application is complete and ready for submission.

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AZ&Me Prescription Savings Program Application Checklist

The following items must be submitted by mail or by fax to complete your application, even if you have completed the application online. Keep this page for your records.

Send ALL the following TOGETHER:

☐ A completed application, signed and dated by you and your prescriber
Blank applications can be found on www.azandmeapp.com. If you are applying for assistance with SYNAGIS® (palivizumab), please use the AZ&Me Application for SYNAGIS. If you are applying for one of the following products, please use the AZ&Me Application for Specialty Products: CALQUENCE® (acalabrutinib), FASENRA™ (benralizumab), FASLODEX® (fulvestrant), IMFINZI® (durvalumab), IRESSA® (gefitinib), LYNPARZA® (olaparib), TAGRISSO® (osimertinib)

☐ The completed prescription on page 3 of this application

☐ Proof of household income (include only **one** of the following):
- A copy of last year's federal income tax returns for yourself, spouse, and dependents
- All income statements from jobs last year (W2 or 1099)
- Two current paystubs
- Current Social Security Income Yearly Benefits Statement
- **If current household income is zero**, a letter explaining your financial situation from a family member, healthcare provider, or yourself

☐ If you are a Medicare Part B or Medicare Part D enrollee, please also include:
- A copy of the front and back of your Medicare Rx card (for Part D) or your Medicare enrollment card (for Part B)
- A copy of your Medicare Part B and/or Medicare Part D Prescription Drug Plan statement (Explanation of Benefits [EOB]), a pharmacy printout, or a summary document from your pharmacy indicating the amount you have spent for prescriptions in the current calendar year; this total should be at least 3% of your income

Please do not send your medical records or Statement of Medical Necessity form with your application.

MAIL your completed application, prescription, and required proof of income documentation to:

AZ&Me Prescription Savings Program
PO Box 898
Somerville, NJ 08876

Or

Your doctor's office may FAX your completed application, prescription and required documentation, with a fax cover sheet. For BRILINTA® (ticagrelor): 1-866-801-5480. For FASENRA™ (benralizumab), SYNAGIS® (palivizumab) or IMFINZI® (durvalumab): 1-855-686-8795. For CALQUENCE® (acalabrutinib), FASLODEX® (fulvestrant), IRESSA® (gefitinib), LYNPARZA® (olaparib), or TAGRISSO® (osimertinib): 1-877-239-0867. For all other products: 1-800-961-8323. **Applications and prescriptions not faxed from the doctor's office will be deemed invalid.**

Important Information about your Application

Information provided to us will be used to determine possible eligibility for help from another program such as Medicaid. You may be required to submit documentation supporting that you do not qualify for other prescription assistance.

For Prescription Refills, call 1-800-292-6363

Once you are enrolled in the Program, your prescriptions can easily be refilled by calling our automated phone line 24 hours a day, 7 days a week.

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Prescription Information

PATIENT INFORMATION: *Please print clearly in **blue or black** ink.*

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____
(This information will only be used to determine eligibility.) *(MM/DD/YYYY)*

Name: _____
First *Middle Initial* *Last*

Address: _____ City: _____ State: _____ Zip: _____

☐ Patient has no current address. (Medication will be shipped to HCP's office)

Phone: (_____) _____ Alternate Phone: (_____) _____ E-mail: _____

☐ New Application ☐ Re-enrollment Please note: Medications can not be shipped to Post Office (PO) boxes.

PRESCRIBER INFORMATION:

This form will replace all previous prescriptions that may have been sent. All fields are required, eg, BRAND NAME, strength, directions for use, quantity, and refills

Prescriber Name: _____ Phone: (_____) _____ Fax: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

DEA: _____ NPI: _____ State License Number (SLN): _____

Office Contact Name: _____ Phone: (_____) _____ Practice Name: _____

Medication/Strength and Directions:	QTY:	Refills:

SHIP MEDICATION TO: ☐ **PATIENT** ☐ **PRESCRIBER***

*(*For Prescribers in Ohio ONLY: Pursuant to OAC 4729-5-10, Ohio prescribers must be approved by the Ohio Board of Pharmacy to be a pick-up station)*

Prescriber Signature: _____ ***Date:*** _____

NY Prescribers must attach a separate prescription in accordance with NY pharmacy law.

Source ID: _____

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Program Eligibility Information: *Please print clearly in **blue or black** ink.*

Name: _____ Social Security Number:_____-_____-_____
First *Middle Initial* *Last*

If you don't have a Social Security Number you must provide one of the following:

☐ Green Card (Please provide number):_____ ☐ Work Visa (Please provide number): _____

Primary language spoken: ☐ English ☐ Spanish ☐ Other:_____

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widow/Widower

Disabled (approved by Social Security): ☐ Yes ☐ No

INCOME:

What is the total combined household income before taxes? *(Include yourself, all adults, and all dependents)*

Note: You will need to provide proof of income with your application.

$_____Monthly OR $_____Yearly

Number of people in your household: _____Number of dependents in your household under 18 years of age: _____

(Include yourself, all adults, and all dependents)

INSURANCE:

Do you have any form of prescription drug coverage? ☐ Yes ☐ No If yes, please provide plan name and ID number: _____

If Yes, please check all that apply:

☐ Employer-furnished or private drug coverage

☐ VA or Military Benefits ☐ Other Prescription Coverage _____

☐ Medicare Part A (hospital) ☐ Medicaid State Assistance program for medicines

☐ Medicare Part B (medical) **if requested medication is covered under Part B, provide copy of Medicare card (front and back)**

☐ Medicare Part D (prescriptions) **provide copy of Part D card (front and back)**

☐ Extra Help/Limited Income Subsidy

If the requested medication is covered under Medicare Part B or Part D, how much have you spent on prescription medicines through your Medicare benefit during the current year? $_____

Do you have supplemental (Medigap) coverage? ☐ Yes ☐ No

If so, does your supplemental coverage cover your total out-of-pocket cost for your medication? ☐ Yes ☐ No

CONSENT:

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 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.

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I PROMISE that all the information in this application, including all copies of documents proving my income, is true and complete; I am authorized to sign this application; I do not have any assistance or insurance that would help pay for my medicines (other than Medicare Part D, 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 Part D plans; share my information with the Centers for Medicare and Medicaid Services.

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; cancel my permission to use my information and withdraw from the Program; get a copy of the AstraZeneca Privacy Statement.

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.

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 about my application (this only applies if someone completed this application for you).

This authorization form will be effective for 1 year 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**.**

Signature of Applicant or Legal Guardian

X_____**Date:**_____/_____/_____(MM/DD/YYYY)

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: (* _____ *)* _____

AstraZeneca