

Application for Free AstraZeneca Medicines:

PO Box 222178, Charlotte, NC 28222



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 renewal documents as your enrollment end date approaches
- Your medication may be sent to your home or to your doctor's office

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 resident
- ✓ You meet certain household income limits
(visit www.azandmeapp.com or call **1-800-292-6363** or **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 B or Part D
 - You participate in Medicare Part B, Medicare Part D or Medicare Advantage

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

AZ&Me Prescription Savings Program Application Checklist

The following items must be submitted by mail or by fax to complete your application. 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 (Oncology & Respiratory/Immunology Biologics Products), please use the AZ&Me Application for Specialty Care Products.
- The completed prescription on page 3 of this application

Please do not send your medical records with your application.

MAIL your completed application, prescription, and Medicare documentation (if applicable) to:

AZ&Me Prescription Savings Program
PO Box 222178
Charlotte, NC 28222

Or

Your doctor's office may FAX your completed application, prescription and required documentation, with a fax cover sheet. For all non-specialty 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 contacting our phone line Monday through Friday, 9:00 AM – 6:00 PM ET.

Questions? Call **1-800-292-6363** Monday–Friday, 9:00 AM to 6:00 PM ET or visit **www.azandmeapp.com**

Non-Specialty Products Fax: 1-800-961-8323

PATIENT INFORMATION:

Please print clearly in **blue or black ink**. Asterisks indicate required fields.

New Application Re-enrollment

Patient Name*: _____
First Middle Initial Last

Date of Birth*: ____/____/____
(MM/DD/YYYY)

If covered by Medicare include your Medicare MBI number found on your Medicare card*: _____

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

Patient has no current address. (Medication will be shipped to HCP's office) Please note: Medications cannot be shipped to Post Office (PO) boxes.

Please check box for preferred phone number to contact you: Phone*: (____) _____ Mobile Phone: (____) _____

E-mail: _____

Primary language spoken: English Spanish Other: _____

PRESCRIBER INFORMATION: This form will replace all previous prescriptions that may have been sent.



This section MUST be completed by Prescribing Physician



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

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

Prescriber E-mail: _____ NPI*: _____ State License Number (SLN): _____

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

Medication*	Strength*	Dosage*	Frequency/Directions * (for weight-based medications please include exact dose or patient weight)	Quantity*	Refills*	Form* - Syringe - Pen - Vial - Oral - Inhaler

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: (must be wet signature) _____ **Date:** _____

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

Questions? Call **1-800-292-6363** Monday–Friday, 9:00 AM to 6:00 PM ET or visit **www.azandmeapp.com**

Non-Specialty Products Fax: 1-800-961-8323

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

INCOME:

Income Verification: 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.

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

\$ _____ 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 check all that apply:

Employer-furnished or commercial/private drug coverage. Please provide plan name and ID number: _____

VA or Military Benefits Other Prescription Coverage _____

Medicaid Prescription Drug Coverage

Medicare Part B (medical benefit that covers some prescription medications)

Medicare Part D (prescription drug coverage). Please provide payer name: _____

Medicare Part D Member ID: _____

Medicare Low Income Subsidy (LIS)

Do you have Medicare 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, 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.

Questions? Call **1-800-292-6363** Monday–Friday, 9:00 AM to 6:00 PM ET or visit **www.azandmeapp.com**

Non-Specialty Products Fax: 1-800-961-8323

CONSENT:

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.

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.

Text me about AZ&Me Patient Assistance Program information. By checking this box, I consent to receive text messages after enrollment into AZ&Me Patient Assistance Program. For each program service, I will receive a welcome text asking me to reply CONFIRM to opt-in. Message and data rates may apply; number of messages varies based on program use but is up to 10 texts per month. Reply STOP to cancel. Privacy Notice and full Terms available at <https://www.globalprivacy.astrazeneca.com/> or <http://goto.az/azmetc>. If this box is NOT checked, you will NOT receive text messages from the AZ&Me Patient Assistance Program

Please provide the mobile phone number you would like to receive texts _____

Signature of Applicant or Parent/Legally Authorized Representative. *If patient is a minor, parent or legally authorized representative should sign here.*

Relation to Patient: Patient Parent Legally Authorized Representative of Patient

Patient Name _____

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: (_____) _____

Note: If a helper's name is not provided, they will not be able to act on the patient's behalf without a separate authorization from the patient.

