TEZSPIRE™ (tezepelumab-ekko) Subcutaneous Injection 210 mg | TEZSPIRE™ together

Program Enrollment Form

Note: Section 1 to be completed and signed by the patient or legal representative

An asterisk (*) indicates a required field.

1 PATIENT INFORMATION

Sex Assigned at Birth:* ☐ Male ☐ Female ☐ Not Specified

First Name:* _____ Last Name:* _____ Date of Birth:* ____ / ____ / _____

Street:* _____ City:* _____ State:* ____ ZIP Code:* _____

Email:* _____ Phone:* _____ ☐ Home ☐ Mobile

Preferred Form of Contact: ☐ Phone ☐ Text ☐ Email Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

Preferred Language (if not English): _____

PATIENT AUTHORIZATION

Legal representative is required if patient is younger than 18 years of age. I have read and agree to the Authorization to Use and Disclose Personal Information on page 3.

Signature of Patient/Legal Representative:* _____ **Name of Patient/Legal Representative:*** _____ Date:* ____ / ____ / _____

Legal Representative Phone (If different from above): _____ **Relationship to Patient:** _____

TEZSPIRE Together Fast Start Terms & Conditions (Commercially Insured Patients Only)

If you have commercial insurance and your health plan does not cover TEZSPIRE or requires a prior authorization, you may be eligible to receive TEZSPIRE free for up to twelve (12) doses within twenty-four (24) months from the date the first dose is filled. See full Terms and Conditions on page 4.

☐ By checking this box, I agree that I read, understand, and accept the **Terms and Conditions** of the Fast Start Program on page 4.

2 INSURANCE INFORMATION

☐ Commercial/Private Insurance ☐ Medicare/Medicaid/TRICARE ☐ No Insurance

If you are acquiring the product via buy and bill, medical insurance is required. If you are acquiring via Specialty Pharmacy, provide both medical and pharmacy insurance information to see if medical insurance could result in a lower out-of-pocket cost for your patient.

	Primary Medical Insurance*	Pharmacy Insurance		Secondary Medical Insurance
Insurance Provider				
Insurance Phone #				
Cardholder Name (if not the patient)				
Cardholder Date of Birth				
Policy #				
Group #				
RxBIN/RxPCN	X	RxBIN:	RxPCN:	X

Patient or legal representative: visit **TEZSPIRETogether.com** or call **1-888-TZSPIRE (1-888-897-7473)** to enroll in the TEZSPIRE Together Co-pay Program (for eligible commercially insured patients only) or to see if you may be eligible for other financial support.

Please see Indication and Important Safety Information on Page 5.

Please **COMPLETE** and **FAX** pages 1 and 2 to **1-888-388-6016**. For additional assistance, **CALL 1-888-TZSPIRE (1-888-897-7473)**, 8AM – 8PM ET, Monday – Friday. Please visit TEZSPIRETogetherHCP.com for additional resources.

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Program Enrollment Form

An asterisk (*) indicates a required field.

First Name:* _____ Last Name:* _____ Date of Birth:* ___ / ___ / _____

3 PROGRAM SERVICES

How will you obtain TEZSPIRE?* ☐ Buy and Bill ☐ Specialty Pharmacy (complete section 6) ☐ I'm Not Sure

Preferred Specialty Pharmacy: _____ Site Type: ☐ Healthcare Provider Office ☐ Hospital Outpatient

TEZSPIRE Together Service Request (check all that apply):

☐ **Benefits Verification:** Verify your patient's insurance coverage for TEZSPIRE and obtain a Summary of Benefits

- ☐ **Transfer to Specialty Pharmacy:** TEZSPIRE Together to transfer the Rx to the preferred or mandated Specialty Pharmacy (complete section 6)

☐ **Fast Start Program:** The Fast Start Program provides up to 12 free doses to eligible commercially insured patients whose plans do not cover TEZSPIRE or require a prior authorization (PA). For immediate enrollment in Fast Start, please complete section 6 and check the box for **Fast Start** and confirm the patient has completed section 1. TEZSPIRE Together **will** run a Benefits Verification to confirm eligibility even if the service isn't requested above

- ☐ By checking this box, I acknowledge that the PA must be submitted within 60 days of the first Fast Start shipment. Additionally, if the PA is denied, an appeal must be submitted within 60 days of denial. Noncompliance with these terms will result in the patient no longer being eligible for the Fast Start Program

☐ **PA and Appeals Support:** Identify the PA and appeal requirements based on plan criteria, help initiate and submit a PA, and track the status of a submission

4 CLINICAL INFORMATION

ICD-10-CM Code:* ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ Other/Misc: _____

Known Drug Allergies:* _____ ☐ History of positive skin or specific IgE (test to perennial aeroallergen)

Absolute Eosinophil Count: _____ cells/mcL Test Date (MM/DD/YYYY): _____

Pre-treatment serum IgE level: _____ IU/mL Test Date (MM/DD/YYYY): _____

Number of severe asthma exacerbations in the past 12 months: _____

Number of ED visits or hospitalizations in the past 12 months: _____

5 PRESCRIBER INFORMATION

Prescriber Name:* _____ Prescriber NPI #:* _____

Practice/Clinic Name: _____ Office Contact Name: _____

Street:* _____ City:* _____ State:* _____ ZIP Code:* _____

Phone:* _____ Fax:* _____ Office Contact Email: _____

6 PRESCRIPTION INFORMATION (complete this section if you are using a Specialty Pharmacy and/or the Fast Start Program)

☐ **Prescription: TEZSPIRE (tezepelumab-ekko)** 210 mg/1.91 mL (110 mg/mL) single-dose prefilled syringe injection

SIG: 210 mg administered SC once every 4 weeks

Office Administered (NDC: 55513-112-01)

Quantity Dispensed:* 1 Refills:* ___

☐ **Fast Start:** Optional program that provides up to 12 free doses of TEZSPIRE to eligible commercially insured patients whose plans do not cover TEZSPIRE or require a PA

SIG: 210 mg administered SC once every 4 weeks

Office Administered (NDC: 55513-112-01)

Quantity Dispensed:* 1 Refills:* 11

Prescriber Attestation: If TEZSPIRE is shipped to the prescriber's office, the prescriber accepts TEZSPIRE on behalf of the patient for administration in the office. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

By signing below, I certify as a licensed healthcare professional that the patient named on this form has, or has had, a diagnosis for an FDA-approved indication for TEZSPIRE. I also certify that this is my legal signature.

Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute

Prescriber Signature (dispense as written): _____ Date: _____

Substitution Permitted/Product Selection Permitted/Submission Permissible

Prescriber Signature (substitution permitted): _____ Date: _____

CA, MA, NC, & PR: Interchange is mandated unless the prescriber writes the words "**No Substitution**": _____

Please see Indication and Important Safety Information on Page 5.

Please **COMPLETE** and **FAX** pages 1 and 2 to **1-888-388-6016**. For additional assistance, **CALL 1-888-TZSPIRE (1-888-897-7473)**, 8AM – 8PM ET, Monday – Friday. Please visit TEZSPIRETogetherHCP.com for additional resources.

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Patients to retain pages 3 and 4

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

Uses and Disclosure of Personal Information

Please read the following carefully, then date and sign where indicated in section 1 on page 1

I authorize Amgen, AstraZeneca Pharmaceuticals LP, and their contractors and business partners ("Amgen and AstraZeneca") to use and/or disclose my personal information, including my personal health information, only for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in Amgen and AstraZeneca's TEZSPIRE™ Together program or any other Amgen- and AstraZeneca-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse educator services, adherence program and disease management support);
- To contact, with my permission, my doctor and the rest of my healthcare team and share with them my health information that may be useful for my care;
- To provide me with informational and promotional materials relating to Amgen and AstraZeneca products and services, and/or my condition or treatment; and/or
- To improve, develop, conduct, and evaluate products, services, materials, outcomes/scientific research, and programs related to my condition or treatment
- Outcomes/Scientific research purposes which includes contacting me to participate in focus groups, surveys, research, or interviews. In order for Amgen and AstraZeneca to provide me with the services and/or programs described above, Amgen and AstraZeneca need to collect and use my personal information, including my personal health information. I understand that my personal health information may include any information, in electronic or physical form, in the possession of or derived from a healthcare provider, healthcare plan, pharmacy, pharmaceutical company, laboratory, and/or their contractor ("Healthcare Provider"). This may include select information from or about my medical history and general health, my healthcare plan benefits, payment limits or restrictions covered by my healthcare plan policy, and/or my adherence to my treatment

I authorize my Healthcare Providers to disclose my personal health information to Amgen and AstraZeneca, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Healthcare Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen and AstraZeneca in exchange for disclosing my personal health information and/or for using my information to contact me with communications about Amgen and AstraZeneca products which have been prescribed to me (for example, medication reminder programs) and other patient support services.

Expiration, Right to Obtain a Copy, and Right to Cancel

I understand that by signing this form, I authorize my Healthcare Providers or others who might hold my health information to only release it to Amgen and AstraZeneca employees, as well as to their contractors and business partners, who are performing the services set forth in this Authorization. I also understand I am authorizing my personal information, including my personal health information, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to release my personal health information for the earlier of five (5) years or until my participation in the program ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling 1-888-TZSPIRE (1-888-897-7473) or by writing to Cardinal Health Specialty Solutions, 2730 S. Edmonds Lane, Suite 300, Lewisville, TX 75067. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Healthcare Provider is disclosing my personal health information to Amgen and AstraZeneca on an authorized on-going basis, my cancellation with Amgen and AstraZeneca will be effective with respect to any such Healthcare Providers as soon as they receive notice of my cancellation.

No Effect on Treatment

I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary. I understand that Amgen and AstraZeneca, as well as Healthcare Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment, or other care, to sign this Authorization. Federal law (including HIPAA) requires a signed authorization in order for Amgen and AstraZeneca to collect this information from my Healthcare Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Healthcare Providers.

Information Received From Healthcare Providers

I understand that once my personal health information has been disclosed to Amgen and AstraZeneca, federal privacy laws may no longer apply and protect it from further disclosure. Amgen and AstraZeneca agree, however, to protect my personal health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

Authorization to Contact

I understand and consent to Amgen and AstraZeneca contacting me using the contact information provided in this form to enroll me in, operate, and administer Amgen and AstraZeneca patient support services and/or programs as described above other than promotional communications by telephone or SMS/text. I understand that the operation and administration of certain of these services and/or programs may require that Amgen and AstraZeneca contact me by telephone or SMS/text.

Safety Reporting Follow-up

I understand that for safety reporting purposes, the safety department of AstraZeneca or its trusted processors may contact me for follow-up for the reporting of any adverse events or other safety findings.

Please see Indication and Important Safety Information on Page 5.

Please **COMPLETE** and **FAX** pages 1 and 2 to **1-888-388-6016**. For additional assistance, **CALL 1-888-TZSPIRE (1-888-897-7473)**, 8AM – 8PM ET, Monday – Friday. Please visit TEZSPIRETogetherHCP.com for additional resources.

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FAST START PROGRAM TERMS & CONDITIONS

The TEZSPIRE™ Together Fast Start Program is available to patients who have been prescribed TEZSPIRE and who have commercial or private insurance, including state and federal plans commonly referred to as "healthcare exchange plans." This program helps eligible patients obtain TEZSPIRE while coverage is being secured, up to program limits.

This offer is not valid if patient is uninsured or receiving prescription reimbursement under any federal-, state-, or government-funded healthcare program, such as Medicare, Medicare Advantage, Medicare Part D, the Retiree Drug Subsidy Program, Medicaid, Medigap, Veterans Affairs (VA), the Department of Defense (DoD), or TRICARE or where prohibited by law. It is not valid for cash-paying or uninsured patients. Cash Discount Cards and other noninsurance plans are not valid as primary under this offer. If at any time patient begins receiving coverage under any such federal-, state-, or government-funded healthcare program, patient will no longer be able to use this offer and patient must call 1-888-TZSPIRE (1-888-897-7473) to stop participation. By participating in this offer, patient acknowledges intent to pursue insurance coverage for TEZSPIRE with their healthcare provider. Once insurance approval is obtained, patient is no longer eligible for this offer. No purchase necessary. **This is not health insurance.** Participation is not a guarantee of insurance coverage. Offer is not renewable. This offer is only valid in the United States, Puerto Rico, and the US territories. Other restrictions may apply. This offer is subject to change or discontinuation without notice.

- If the patient's health plan does not cover TEZSPIRE or requires a prior authorization, patient can receive TEZSPIRE free for up to twelve (12) doses within twenty-four (24) months from the date the first dose is shipped under the Fast Start Program.
- Ongoing eligibility after the first 60 days requires that the prior authorization (PA) is submitted by the provider. If the PA is not submitted within 60 days of the first shipment, then patient will no longer be eligible for the Fast Start Program.
- If the PA results in a denial, the provider must submit the appeal within 60 days of the denial. If the appeal is not submitted within 60 days of the denial, then patient will no longer be eligible for the Fast Start Program.

Please see Indication and Important Safety Information on Page 5.

Please **COMPLETE** and **FAX** pages 1 and 2 to **1-888-388-6016**. For additional assistance, **CALL 1-888-TZSPIRE (1-888-897-7473)**, 8AM – 8PM ET, Monday – Friday. Please visit TEZSPIRETogetherHCP.com for additional resources.

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INDICATION

TEZSPIRE is indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.

TEZSPIRE is not indicated for the relief of acute bronchospasm or status asthmaticus.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

Known hypersensitivity to tezepelumab-ekko or excipients.

WARNINGS AND PRECAUTIONS

Hypersensitivity Reactions

Hypersensitivity reactions (e.g., rash and allergic conjunctivitis) can occur following administration of TEZSPIRE. These reactions can occur within hours of administration, but in some instances have a delayed onset (i.e., days). In the event of a hypersensitivity reaction, initiate appropriate treatment as clinically indicated and then consider the benefits and risks for the individual patient to determine whether to continue or discontinue treatment with TEZSPIRE.

Acute Asthma Symptoms or Deteriorating Disease

TEZSPIRE should not be used to treat acute asthma symptoms, acute exacerbations, acute bronchospasm, or status asthmaticus.

Abrupt Reduction of Corticosteroid Dosage

Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with TEZSPIRE. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.

Parasitic (Helminth) Infection

It is unknown if TEZSPIRE will influence a patient's response against helminth infections. Treat patients with pre-existing helminth infections before initiating therapy with TEZSPIRE. If patients become infected while receiving TEZSPIRE and do not respond to anti-helminth treatment, discontinue TEZSPIRE until infection resolves.

Live Attenuated Vaccines

The concomitant use of TEZSPIRE and live attenuated vaccines has not been evaluated. The use of live attenuated vaccines should be avoided in patients receiving TEZSPIRE.

ADVERSE REACTIONS

The most common adverse reactions (incidence ≥3%) are pharyngitis, arthralgia, and back pain.

USE IN SPECIFIC POPULATIONS

There are no available data on TEZSPIRE use in pregnant women to evaluate for any drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. Placental transfer of monoclonal antibodies such as tezepelumab-ekko is greater during the third trimester of pregnancy; therefore, potential effects on a fetus are likely to be greater during the third trimester of pregnancy.

Full Prescribing Information including Patient Information.

You may report side effects related to AstraZeneca products by clicking here.

Please **COMPLETE** and **FAX** pages 1 and 2 to **1-888-388-6016**. For additional assistance, **CALL 1-888-TZSPIRE (1-888-897-7473)**, 8AM – 8PM ET, Monday – Friday. Please visit TEZSPIRETogetherHCP.com for additional resources.

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