AstraZeneca Access 360™ Enrollment Form

Please complete this form carefully and in its entirety to avoid delays in processing your request. If you are completing this form by hand, please print as clearly as possible, and check any boxes that apply.

AFTER COMPLETING THIS FORM, FAX THIS PAGE ALONG WITH PAGES 3 AND 5 TO 1-833-329-2360.

1 Access 360 Services

How will you obtain FASENRA?

☐ **Specialty Pharmacy** (Complete the Prescription Information in Section 6)

☐ **Buy & Bill**

☐ **I am unsure/undecided** (Access 360 will research both Specialty Pharmacy and Buy & Bill options)

Which services are you requesting? (Select all that apply)

☐ **Benefit Investigation with Specialty Pharmacy and Insurance Authorization Research** (Based on the preferred formulation and acquisition method, Access 360 will research the pharmacy and/or medical benefits for your patient)

☐ **Insurance Authorization Follow-up with Appeals Support** (Access 360 will contact the patient's plan to track the status of the required authorization. Patient Authorization must be completed for this service)

☐ **Specialty Pharmacy Triage** (Access 360 will triage the referral to the appropriate specialty pharmacy. Complete the Prescription Information in Section 6)

☐ **Free Limited Supply** (Free, short-term supply of FASENRA while patients wait for insurance [commercial or government-funded] coverage determinations or are otherwise denied immediate access)

2 Patient Information

First Name: _____ MI: _____

Last Name: _____

DOB *(MM-DD-YYYY)*: ____ - ____ - _____ Sex: ☐ M ☐ F ☐ Prefer not to answer

Street: _____ Apt/Suite/Unit: _____

City: _____ State: _____ ZIP: _____

Phone #: ☐ Home ☐ Mobile ____ - ____ - _____ Best time to call: ☐ Morning ☐ Noon ☐ Evening

Email: _____

Preferred Language (if other than English): _____

OK to call patient? ☐ Yes ☐ No OK to leave a detailed voicemail? ☐ Yes ☐ No

Alternate Contact Name: _____

Relationship to Patient: _____

Patient Authorization

I have read and agree to the Patient Authorization included on Page 2.

★ _____ Today's Date: ____ - ____ - _____

Signature of Patient or Legal Representative M M D D Y Y Y Y

_____ _____

First Name of Patient or Legal Representative **Last Name of Patient or Legal Representative**

FASENRA 360 Support Program (Savings Program and Additional Services)

☐ I have read and agree to the Support Program Authorization included on Page 2.

If patient is unavailable to sign, they can visit www.myaccess360paf.com or call 1-833-360-4357 to complete authorizations.

PATIENT AUTHORIZATION

I authorize my health care providers (HCPs) and staff, my health plan, and my pharmacies to use and share Protected Health Information (my "Information") with AstraZeneca (including AstraZeneca Access 360™) and its affiliates, as well as its contractors ("AstraZeneca"), and my pharmacies may receive payment from AstraZeneca in exchange for sharing my Information and/or providing support services, which may be considered marketing pursuant to this Authorization. My Information includes my prescription-related health records, Information about my health care plan benefits, demographic, contact, and any other Information bearing on my health. My Information may be used to verify treatment and payment decisions with my HCPs; investigate and assist with coordination of coverage for AstraZeneca products; coordinate prescription fulfillment and financial assistance; coordinate educational nursing support; and perform internal analysis at AstraZeneca to better meet patient needs. I understand and agree that AstraZeneca may contact me by mail, email, telephone, and text. I understand that federal privacy laws may not protect my Information once it is disclosed; however, AstraZeneca agrees to protect my Information by using and disclosing it only for purposes specified. I understand that I can refuse to sign this Authorization and that this will not affect my treatment or payment for treatment, insurance coverage, or eligibility for benefits. However, if I do not sign this Authorization, I will not be able to receive AstraZeneca Access 360™ support. I understand that I may request a copy of or cancel this Authorization at any time by calling 1-800-236-9933 or by mailing a letter requesting such cancellation to AstraZeneca Access 360™ 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. This Authorization expires two (2) years from the date signed, unless a shorter period is required by state law.

FASENRA 360 SUPPORT PROGRAM AUTHORIZATION

By providing consent, I understand that I may receive ongoing information and support related to my condition which includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my medical condition or therapy, as well as for market research purposes which includes contacting me to participate in focus groups, surveys or interviews. This may include AstraZeneca or a third party working on AstraZeneca's behalf contacting me by mail, telephone, email and/or text message regarding AstraZeneca support programs that may be of interest to me. I consent to receive marketing and non-marketing calls and texts from and on behalf of AstraZeneca, made with an auto-dialer or prerecorded voice, at the phone number(s) provided. Message and data rates may apply. My Information may also be used to perform internal analysis at AstraZeneca. I understand that I can refuse to provide this Authorization and that this will not affect my treatment or payment for treatment, insurance coverage, or eligibility for benefits. I understand that my consent is not required or a condition of purchase. I understand that I may cancel this Authorization at any time by calling 1-800-236-9933 or by mailing a letter requesting such cancellation to AstraZeneca Access 360™ at One MedImmune Way, Gaithersburg, MD 20878. Information provided by AstraZeneca does not take the place of talking to your health care provider about your treatment or condition. AstraZeneca will not knowingly collect, use, or disclose personally identifiable information from a minor under the age of 18. If you are under the age of 18, please have your parent, guardian, or health care provider request the information on your behalf. Please visit www.globalprivacy.astrazeneca.com to review our Privacy Notice.

AstraZeneca Access 360™ Enrollment Form

Fasenra® (benralizumab) Subcutaneous Injection 30 mg | AstraZeneca Access 360™

Patient First Name: _____ Last Name: _____ DOB: ____ - ____ - ____

AFTER COMPLETING THIS FORM, FAX THIS PAGE ALONG WITH PAGES 1 AND 5 TO 1-833-329-2360.

3 Insurance Information

Is the patient insured? ☐ Yes ☐ No

If insured, please fill out the information below and include front and back copies of all medical and pharmacy cards along with this completed form.

☐ Commercial/Private Insurance ☐ Medicare/Medicaid/Tricare

If your patient is without prescription coverage or on Medicare and cannot afford their medication, AZ&Me™ may be able to help. Visit www.azandmeapp.com or call 1-800-292-6363 for more information.

	Primary Medical Insurance	Secondary Medical Insurance	Pharmacy Insurance (Rx BIN/PCN)	
Insurance Provider				
Insurance Phone #				
Cardholder Name (if not the patient)				
Cardholder DOB				
Policy #				
Group #				
RxBIN/RxPCN	X	X	RxBIN:	RxPCN:

4 Prescriber Information

By completing this form, I certify that **(1)** I have received the necessary authorization to release the information included on this form and other related Protected Health Information (as defined by HIPAA) to AstraZeneca Access Services including employees, contractors, or affiliates of AstraZeneca, and health care plans for programs, dispensing pharmacy(ies) or other entities for the purposes of treatment and payment support, and **(2)** I have obtained any necessary authorization to allow AstraZeneca Access Services to contact the patient or caregiver, if not included with this submission, to obtain a signed Patient Authorization.

First Name: _____ Suffix: _____

Last Name: _____

Practice Name: _____ Phone #: _____ - _____ - _____

Street: _____ Apt/Suite/Unit: _____

City: _____ State: _____ ZIP: _____

Office Staff Name: _____

Office Staff Phone #: _____ - _____ - _____ Fax #: _____ - _____ - _____

Office Staff Email: _____

Prescriber NPI #: _____ Medicare Provider # (PTAN): _____

Group NPI #: _____

AstraZeneca Access 360™ Enrollment Form

Fasenra® (benralizumab) Subcutaneous Injection 30 mg | AstraZeneca Access 360™

Patient First Name: _____ Last Name: _____ DOB: ____ - ____ - ____

AFTER COMPLETING THIS FORM, FAX THIS PAGE ALONG WITH PAGES 1 AND 3 TO 1-833-329-2360.

5 Clinical Information

ICD-10-CM Diagnosis Code:

- ☐ **J45.50** Severe persistent asthma, uncomplicated
- ☐ **J45.51** Severe persistent asthma with (acute) exacerbation
- ☐ **J82.83** Eosinophilic asthma
- ☐ **Other:** _____

Eosinophil Count: _____ cells/µL

Most Recent Test: ____ - ____ - ____ (M M - D D - Y Y Y Y)

Is the patient dependent on systemic corticosteroids?

☐ Yes ☐ No

6 Prescription Information

Complete this section if utilizing an SPP.

Rx FASENRA® (benralizumab)

Please indicate your primary (1st) and alternate (2nd) formulation preferences. If your primary choice is not covered, the alternate formulation may be pursued.

1ST 2ND

- ☐ ☐ FASENRA® (benralizumab) 30 mg/mL single-dose prefilled syringe **Office-Administered** (10-digit NDC: 0310-1730-30)
- ☐ ☐ FASENRA Pen® (benralizumab) 30 mg/mL single-dose autoinjector **Self-Administered** (10-digit NDC: 0310-1830-30)

Has the patient started therapy? ☐ Yes ☐ No

If yes, how many doses has the patient received? _____ Last Injection Date: ____ - ____ - ____ (M M - D D - Y Y Y Y)

- ☐ **Loading Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 4 weeks for 3 doses** Quantity: _____ Refills: _____
- ☐ **Maintenance Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 8 weeks** Quantity: _____ Refills: _____

Known Allergies: _____

Other Medications: _____

Optional: Free Limited Supply (FLS) Request

Free Limited Supply is available for eligible patients who face a delay in approval by their insurance company for FASENRA.

FASENRA® (benralizumab) Quantity: _____

Dose Instructions: _____

Please read **Prescriber Authorization** on Page 6 before signing.

Prescriber First Name: _____

Last Name: _____

NPI #: _____ **State License #:** _____

★ _____ Date: ____ - ____ - ____ (M M - D D - Y Y Y Y)

Prescriber Signature: Dispense as written

_____ Date: ____ - ____ - ____ (M M - D D - Y Y Y Y)

Prescriber Signature: Substitution permitted

After completing and faxing the appropriate pages, you may need to provide additional information depending on the type of support requested.

PRESCRIBER AUTHORIZATION

I authorize Access 360 program to convey the attached prescription on my behalf to the pharmacy chosen above and to receive information on the status and related matters. By signing on Page 5, I certify that the medicine prescribed on this form is medically necessary based on my independent medical judgment, and I have received the necessary authorization to release the information included on this form and other Protected Health Information (as defined by HIPAA) to Access 360, the dispensing pharmacy, or other contractors for the purpose of seeking reimbursement or assisting in initiating or continuing therapy. Each practitioner is solely responsible for ensuring the accuracy of the information submitted.

I verify that the information provided on this form is accurate. I understand that the patient must have a diagnosis consistent with an FDA-approved indication for FASENRA to be eligible for free limited supply. I also understand I must submit a prescription compliant with my state law. Reimbursement for the cost of the product administered to the above patient on the date(s) indicated has not been sought and will not be sought from any source. Additionally, I understand that AstraZeneca reserves the right to conduct periodic audits of the records, excluding patient-identifiable data (unless patient authorization is on file with Access 360), of all entities receiving free limited supply. I understand that AstraZeneca reserves the right to modify or revoke this program at any time without notice. My signature confirms that this product was provided free of charge to this patient. (Using signature stamp or signing on behalf of the prescriber is not permitted).

Once completed and signed, please **fax pages 1, 3, and 5** to **1-833-329-2360**.

1-833-360-HELP (1-833-360-4357)

1-833-FAX-A360 (1-833-329-2360)

Access360@AstraZeneca.com

***.FasenraResources.com

One MedImmune Way, Gaithersburg, MD 20878

AstraZeneca

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