Saphnelo™ SUPPORTS | AstraZeneca Access 360

ENROLLMENT FORM

Saphnelo™ (anifrolumab-fnia) Intravenous Use 300 mg/vial

Please complete form, sign, and fax all pages to 1-866-511-2360.
For questions or assistance, please call Access 360™ Monday–Friday, 8 AM–8 PM ET at 1-866-SAPHNELO (1-866-727-4635).

1 How Do You Plan on Obtaining SAPHNELO?

☐ **Buy and Bill**

☐ **Specialty Pharmacy** (**Note:** Complete prescription information in section 7)

☐ **Undecided** (**Note:** Access 360 will research both Specialty Pharmacy and Buy and Bill options)

What Services Are You Requesting?

☐ **Benefits investigation:** includes prior authorization, precertification, or predetermination, and specialty pharmacy research

☐ **Insurance authorization follow-up with appeals support** (**Note:** Patient must read Patient Authorization on page 2 and sign below)

☐ **Recertification/reauthorization support** (**Note:** Patient must read Patient Authorization on page 2 and sign below)

☐ **Specialty pharmacy triage:** Access 360 will determine the specialty pharmacy for the patient and submit the referral (**Note:** Not applicable to Buy and Bill option)

☐ **Claims/billing support:** (**Note:** Attach a copy of the claim submitted and the Explanation of Benefits)

Scan to download the SAPHNELO™ Supports Patient Playbook

2 Patient Information

Patient's First name, Last name, DOB, Street, City, State, and ZIP are required and must be filled out by the office.

First name: _____ **Last name:** _____ **Patient DOB:** ___/___/_____ MM DD YYYY

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

Preferred phone #: ☐ Home ☐ Mobile _____ **Best time to call:** ☐ Morning ☐ Afternoon ☐ Evening

OK to contact patient? ☐ Yes ☐ No **OK to leave a detailed voicemail?** ☐ Yes ☐ No

Has the patient received the Patient Welcome Kit? ☐ Yes ☐ No

Communication preference (choose one): ☐ Email ☐ Text ☐ Both **Patient email:** _____

Preferred language (if other than English): _____

Alternate contact name: _____ **Relationship to patient:** _____

Alternate contact phone #: _____

Patient Authorization

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

_____ / /

Patient signature/Legal representative MM DD YYYY **Today's date**

_____

Printed name/Relationship to patient (if applicable)

SAPHNELO Supports Savings Program, and Additional Support

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

_____ / /

Patient signature/Legal representative MM DD YYYY **Today's date**

_____

Printed name/Relationship to patient (if applicable)

If patient is unavailable to sign, they can call Access 360 at 1-866-SAPHNELO (1-866-727-4635) or visit www.myaccess360paf.com to complete the authorization electronically.

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Patient first name: _____ **Patient last name:** _____ **Patient DOB:** ___/___/_____
MM DD YYYY

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 Services) and its affiliates, as well as its contractors ("AstraZeneca"). 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 Services support. 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 Services 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.

SAPHNELO™ Supports Authorization Savings Program, and Additional Support

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 Services 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 healthcare provider request the information on your behalf. Please visit www.globalprivacy.astrazeneca.com to review our Privacy Notice.

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Patient first name: _____ **Patient last name:** _____ **Patient DOB:** ___/___/_____
MM DD YYYY

3 Insurance Information

Is the patient insured? ☐ Yes ☐ No

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

If insured, please fill out the information below and include front and back copies of all medical and pharmacy cards or face sheet.

☐ Commercial/private insurance ☐ Medicare/Medicaid/TRICARE

	Primary medical insurance	Secondary medical Insurance	Pharmacy insurance
Insurance provider			
Insurance phone #			
Cardholder name (if not the patient)			
Cardholder DOB			
Policy #			
Group #			
			RxBIN/RxPCN:

4 Clinical Information

ICD-10-CM diagnosis codes (required):

☐ M32.10: Systemic lupus erythematosus, organ or system involvement unspecified
☐ M32.11: Endocarditis in systemic lupus erythematosus
☐ M32.12: Pericarditis in systemic lupus erythematosus
☐ M32.13: Lung involvement in systemic lupus erythematosus
☐ M32.14: Glomerular disease in systemic lupus erythematosus
☐ M32.15: Tubulo-interstitial nephropathy in systemic lupus erythematosus
☐ M32.19: Other organ or system involvement in systemic lupus erythematosus
☐ M32.8: Other forms of systemic lupus erythematosus
☐ M32.9: Systemic lupus erythematosus, unspecified

Positive ANA or anti-dsDNA test? ☐ Yes ☐ No

Date of test: ___/___/_____
MM DD YYYY

Previous systemic lupus erythematosus (SLE) treatment(s):

_____

_____

Current SLE treatment(s):

_____

_____

5 Provider Information

Prescriber name: _____

Specialty: _____

Collaborating physician (if applicable): _____

Practice name: _____

Office contact name: _____

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Phone #: _____ **Ext:** _____

Best time to call: _____ **Fax #:** _____

Email: _____

Prescriber NPI #: _____

Tax ID #: _____

PTAN: _____

Group NPI #: _____

Other payer-specific provider #: _____

By signing this form below, 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.

_____
Printed name

_____
HCP office staff signature

Today's date: ___/___/_____
MM DD YYYY

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This page is required for pharmacy coordination and a free limited supply request.
IF YOU ARE REQUESTING A BENEFITS INVESTIGATION, INSURANCE AUTHORIZATION SUPPORT, OR APPEALS SUPPORT, YOU ONLY NEED TO COMPLETE PAGES 1 AND 3.

Patient first name: _____ **Patient last name:** _____ **Patient DOB:** ___/___/_____ MM DD YYYY

6 Alternate Site of Care (ASOC) Information

ONLY complete this section if the place of administration differs from the prescribing office.

Place of infusion: ☐ Other physician's office ☐ Hospital outpatient ☐ Home health/Home infusion ☐ Other: _____

Administering practice/facility: _____ **Administering physician name:** _____

Street: _____ **City:** _____ **Phone #:** _____ **Fax #:** _____

NPI #: _____ **Tax ID #:** _____ **PTAN:** _____ **Other payer-specific provider #:** _____

Access 360 **will not triage** or communicate benefits investigation results or script to the ASOC listed. Access 360 **will only** confirm if the ASOC is in-network.

7 Prescription Information

In-network specialty pharmacy providers (SPPs)

☐ AMBER SPECIALTY PHARMACY ☐ CVS SPECIALTY ☐ No preference

If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-866-SAPHNELO (1-866-727-4635).
By choosing "No preference," an SPP will be chosen based on the results of the benefit investigation.

SAPHNELO™ (anifrolumab-fnia)

☐ SAPHNELO™ (anifrolumab-fnia) 300 mg administered as an IV infusion over a 30-minute period, every 4 weeks.
Quantity: _____ Refills: _____ Known allergies: _____

☐ **OPTIONAL: Free limited supply request**
Free limited supply is available for eligible patients who face a delay in approval by their insurance company for SAPHNELO.

SAPHNELO™ (anifrolumab-fnia)
Quantity: 1 Dose instructions: _____

Please read Prescriber Authorization below before signing.

Prescriber name	**NPI #**	**State license #**
Prescriber signature: Dispense as written	**Today's date:** MM / DD / YYYY	
Prescriber signature: Substitution permitted	**Today's date:** MM / DD / YYYY	

NOTE: Sign by hand. (No digital signature or stamps.)

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 below, 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 an FDA-approved diagnosis 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, fax this form to 1-866-511-2360. You may need to provide additional information depending on the type of support requested.

1-866-SAPHNELO (1-866-727-4635) **1-866-511-2360** **www.MyAccess360.com**

Access360@AstraZeneca.com **One MedImmune Way,** Gaithersburg, MD 20878

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