Saphnelo® SUPPORTS | AstraZeneca Access 360™

ENROLLMENT FORM

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

AFTER COMPLETING THIS FORM, FAX THIS PAGE ALONG WITH PAGES 3 AND 4 TO 1-866-511-2360. For questions or assistance, please call AstraZeneca Access 360™ Monday – Friday, 8 AM – 6 PM ET at 1-866-SAPHNELO (1-866-727-4635).

1 AstraZeneca Access 360™ Services

How will you obtain SAPHNELO?

☐ **Buy and Bill** ☐ **Specialty Pharmacy** (**Note:** Complete prescription information in section 7) ☐ **I am unsure/undecided** (**Note:** AstraZeneca 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)

☐ **Specialty pharmacy triage:** AstraZeneca Access 360™ will triage the referral to the appropriate specialty pharmacy based on the patient's benefits. (**Note:** Not applicable to Buy and Bill option)

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

☐ **Free Limited Supply:** Free, short-term supply of SAPHNELO for eligible patients who are denied immediate access or awaiting insurance coverage determination

2 Patient (Pt) Information

Patient's first name, last name, DOB, street, city, state, and ZIP are required and must be filled out by the office.

Pt First Name: _____ **Pt Last Name:** _____ **Pt DOB:** MM-DD-YYYY

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

Pt Phone #: _____ ☐ Home ☐ Mobile **OK to call patient?** ☐ Yes ☐ No

OK to leave a detailed voicemail? ☐ Yes ☐ No **Gender at birth** ☐ M ☐ F ☐ Prefer not to answer

Communication Preference (choose one): ☐ Email ☐ Text ☐ Both **Pt Email:** _____

Preferred Language (if other than English): _____

Alternate Contact First Name: _____ **Alternate Contact Last Name:** _____

Relationship to Patient: _____ **Alternate Contact Phone #:** _____

Patient Authorization

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

_____ MM_DD_YYYY

Signature of Patient or Legal Representative **Today's Date**

_____ _____

Printed Name **Relationship to Patient**

SAPHNELO® Supports (Savings Program and Additional Support)

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

If patient is unavailable to sign, they can call AstraZeneca Access 360™ at **1-866-SAPHNELO** (1-866-727-4635) or visit www.azpatientsupport.com 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 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 360 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 360 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 360 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 insurance 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.

☐ 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:	X	X	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
☐ Other: _____

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 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 360 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 360 Services to contact the patient or caregiver, if not included with this submission, to obtain a signed Patient Authorization.

Provider First Name: _____ **Provider Suffix:** _____

Provider Last Name: _____

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

Practice Street: _____ **Practice Apt/Suite/Unit:** _____

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

Office Staff First Name: _____

Office Staff Last Name: _____

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

Office Staff Email: _____

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

Group NPI #: _____ **Tax ID #:** _____

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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:** _____

ASOC Street: _____ **ASOC City:** _____ **ASOC Phone #:** _____

ASOC Fax #: _____ **ASOC NPI #:** _____ **Tax ID #:** _____ **PTAN:** _____

Other payer-specific provider #: _____

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

7 Prescription Information

ONLY complete this section if utilizing a specialty pharmacy.

In-network Specialty Pharmacy Providers (SPPs)

☐ AMBER SPECIALTY PHARMACY ☐ CVS SPECIALTY ☐ No preference ☐ Axium Healthcare (Puerto Rico only)

By choosing "No preference," an SPP will be chosen based on the results of the benefits 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, short-term supply of SAPHNELO for eligible patients who are denied immediate access or awaiting insurance coverage determination.

SAPHNELO® (anifrolumab-fnia) 300 mg/2 mL single-dose vial

Quantity: 1 Vial Dose instructions: _____

Reminder: Free Limited Supply is a temporary program and does not replace existing affordability programs which may be more appropriate for long-term access barriers.

Please read **Prescriber Authorization** on Page 5 before signing.

Prescriber First Name: _____

Prescriber Last Name: _____

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

_____ MM DD YYYY
Prescriber Signature: Dispense as written **Today's Date**

_____ MM DD YYYY
Prescriber Signature: Substitution permitted **Today's Date**

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

ENROLLMENT FORM

Prescriber Authorization

I authorize AstraZeneca 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 4, 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 AstraZeneca 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 SAPHNELO 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 AstraZeneca 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 4 TO 1-866-511-2360.

1-866-SAPHNELO (1-866-727-4635)

1-866-511-2360

Access360@AstraZeneca.com

www.MyAccess360.com

One MedImmune Way, Gaithersburg, MD 20878