Final Print Size of the following piece will be 8.5 inches wide x 11 inches high.

AstraZeneca

FASLODEX Enrollment Form

US-22732

AstraZeneca Access 360™ Enrollment Form

Services Requested (check only those that apply)

☐ Benefit Investigation ☐ Prior Authorization Research ☐ Pharmacy Coordination ☐ Appeals Support*
☐ Claims/Billing Support ☐ Specialty Pharmacy Follow-up ☐ Payer Follow-up

Please include a copy of the insurance denial letter.

Please complete form, sign, and fax all pages to **1-844-329-2360**.

For questions or assistance, please call Access 360, Monday through Friday, 8 AM – 8 PM at **1-844-275-2360**.

Affordability Support for Patients
To enroll in the FASLODEX Patient Savings Program,† visit www.faslodexsavings.com.
To enroll a patient in the AZ&Me™ Prescription Savings Program (Patient Assistance Program†), visit www.azandmeapp.com.
†Eligibility requirements will apply.

1 Patient Information

First Name: ______ Last Name: ______ Patient DOB: __/__/__ Gender: ☐ M ☐ F
Street: ______ City: ______ State: ______ ZIP: ______
Preferred Phone #: ☐ Home ☐ Mobile ______ Patient Email: ______
Alternate Contact Name: ______ Relationship to Patient: ______
Alternate Contact Phone #: ______ Patient preferred language (if other than English): ______
Okay to contact patient? ☐ Yes ☐ No Okay to leave a detailed voicemail? ☐ Yes ☐ No

Patient Authorization

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

Patient Signature/Legal Representative ______ MM / DD / YYYY

Relationship to Patient (If signed by someone other than the patient, please describe your authority to sign on behalf of the patient.) ______

2 Insurance Information

Please include front and back copies of all medical and pharmacy cards or complete this section.

☐ Commercial/Private Insurance ☐ Medicare/Medicaid/Tricare ☐ No insurance

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

3 Provider Information

Prescriber Name: ______ Specialty: ______
Practice Name: ______ Office Contact Name: ______
Street: ______ City: ______ State: ______ ZIP: ______
Phone #: ______ Fax #: ______ Email: ______
Prescriber NPI #: ______ Tax ID #: ______
PTAN: ______ Other Provider ID (if applicable): ______
Alternate Office Contact Name: ______ Alternate Office Contact Phone #: ______ Alternate Office Contact Email: ______

4 Clinical Information

Diagnosis ICD-10 code(s): ______
Description: ______

By signing 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 Access 360, 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 Access 360 to contact the patient, if not included with this submission to obtain a signed Access 360 Patient Authorization.

HCP Name: ______
HCP Signature: ______ Date: ______

Please complete form, sign, and fax all pages to 1-844-329-2360.

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 Access 360) 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; and perform internal analysis at AstraZeneca to better meet patient needs. I understand and agree that AstraZeneca may contact me by mail, email, and telephone. 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 Access 360 support. I understand that I may cancel this Authorization at any time by calling 1-844-ASK-A360 or by mailing a letter requesting such cancellation to 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 on page 1, unless a shorter period is required by state law.

Patient First Name: ______________________

Patient Last Name: ______________________ Patient DOB: ____/____/______

This page is only required for Pharmacy Triage. If you are requesting Benefits Investigation, Prior Authorization Support, or Appeals Support, you only need to complete page 1.

5 Alternate Site of Care

If administering practice differs from provider practice, then complete this section with administering practice information:

Practice Name: ______________ Office Contact Name: ______________

Phone #: ______________ Fax #: ______________ Site Tax ID: ______________

NPI #: __________ Street: __________ City: __________ State: ______ ZIP: ______

6 Prescription Information

☐ Buy and Bill (prescription information does not need to be completed)

Specialty Pharmacy Provider (SPP)

☐ Preferred Specialty Pharmacy ______________ ☐ No Preference*

**If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-844-275-2360. By choosing "No Preference," the SPP will be chosen based on the results of a Benefit Investigation.*

FASLODEX® (fulvestrant)

250 mg/5 mL prefilled syringe

Quantity: ______________________

Refills: ______________________

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.)

Prescriber Name: ______________________

Prescriber Signature: ______________________ Date: __________

Once completed and signed, fax this form to 1-844-329-2360. You may need to provide additional information depending on the type of support requested.

1-844-ASK-A360 (1-844-275-2360) **1-844-FAX-A360** (1-844-329-2360) **www.MyAccess360.com**

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

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