AstraZeneca Access 360™ Enrollment Form

IMFINZI® durvalumab Injection for Intravenous Use 50 mg/mL | IMJUDO® tremelimumab-actl Injection for Intravenous Use 20 mg/mL | AstraZeneca Access 360™

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 – 6 PM ET at **1-844-275-2360**.

Services Requested

(check only those that apply)

- ☐ Benefit Investigation and Prior Authorization Support
- ☐ Co-Pay Support (Note: You may also visit www.imfinzisavings.com for direct enrollment into the IMFINZI Patient Savings Program) and/or the IMJUDO Patient Savings Program at www.imjudosavings.com (Eligibility rules apply)
- ☐ Pharmacy Coordination
- ☐ Claims/Billing Support (Please attach a copy of the claim submitted and Explanation of Benefits)
- ☐ Appeals Support (Please attach a copy of the denial letter)
- ☐ General referral to independent foundations
- ☐

Medication(s) Requiring Services

- ☐ IMFINZI
- ☐ IMFINZI + IMJUDO*
- ☐ IMJUDO*

*Support services for IMJUDO are available only when prescribed in combination with IMFINZI for certain FDA-approved indications. IMJUDO is not approved as a monotherapy. Please refer to the full Prescribing Information when prescribing IMFINZI and IMJUDO.

To enroll in AZ&Me™ (Patient Assistance Program), visit www.azandmeapp.com. (Eligibility rules apply)

1 Patient Information

Patient DOB: Gender: ☐ M ☐ F

First Name: _____ Last Name: _____

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

_____

Printed Name/Relationship to Patient (if applicable)

Support Programs (Savings Program and Additional Services)

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

_____ / / /

Patient Signature/Legal Representative MM DD YYYY

_____

Printed Name/Relationship to Patient (if applicable)

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	

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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"). 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 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.

Support Programs 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.

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Patient First Name: _____

Patient Last Name: _____ Patient DOB: ____/____/____

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 (to be completed by the healthcare provider)

Diagnosis

ICD-10-CM Diagnosis Code(s)	Description	Histology

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

HCP Name: _____

HCP Signature: _____ Date: _____

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#: _____ Place of Service Code: _____

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

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Patient First Name: _____

Patient Last Name: _____ Patient DOB: ____/____/____

6 Acquisition Information (Choose One)

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

☐ Specialty Pharmacy Provider (SPP) (Please select preferred SPP and complete prescription below, as appropriate)

SPP*

☐ ACCREDO HEALTH GROUP INC. ☐ BIOLOGICS ☐ CENTERWELL ☐ CVS SPECIALTY ☐ OPTUM
☐ ONCO360 ☐ 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.*

IMFINZI® (durvalumab)†

120 mg/2.4 mL vial quantity: _____

500 mg/10 mL vial quantity: _____

Refills: _____

☐ ***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 IMFINZI.

IMFINZI® (durvalumab)†

120 mg/2.4 mL vial quantity: _____

500 mg/10 mL vial quantity: _____

IMJUDO® (tremelimumab-actl)†‡

25 mg/1.25 mL vial quantity: _____

300 mg/15 mL vial quantity: _____

Refills: _____

☐ ***Optional: Free Limited Supply (FLS) Request***

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

IMJUDO® (tremelimumab-actl)†‡

25 mg/1.25 mL vial quantity: _____

300 mg/15 mL vial quantity: _____

†For IMFINZI and/or IMJUDO dosing information, please reference the Coding, Dosage, and Wastage Guide at www.myaccess360.com.
‡Support services for IMJUDO are available only when prescribed in combination with IMFINZI for certain FDA-approved indications. IMJUDO is not approved as a monotherapy. Please refer to the full Prescribing Information when prescribing IMFINZI and IMJUDO.

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

AstraZeneca