Patient Name: _____

Access 360™ Enrollment Form

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

The AstraZeneca Access 360™ program provides personal support to connect patients to affordability programs and streamline access and reimbursement for AstraZeneca's medicines.

About This Form: Use this form to enroll in Access 360. Once completed and signed, fax the form to **1-833-329-2360.** You may need to provide additional information depending on the type of support requested.

Services Requested: Unless indicated below, Access 360 will perform our standard support services, including Benefit Investigation, Affordability, Prior Authorization, Denial, Appeals, and Claims support. If you would like us to perform a specific service, please indicate it here: ☐ Other _____

1 Patient Information

First Name: _____ Last Name: _____ Patient DOB: ___/___/_____

Gender: ☐ Female ☐ Male Patient preferred language (if other than English): _____

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

Patient Phone #: _____ Mobile Phone #: _____ Patient Email: _____

Alternative Contact Name: _____ Relationship to Patient: _____ Alternative Contact Phone #: _____

Okay to contact patient? ☐ Yes ☐ No Okay to leave a voicemail? ☐ Yes ☐ No Has patient received the Patient Welcome Kit? ☐ Yes ☐ No

Insurance Information

☐ **Please include front and back copies of all medical and pharmacy cards**

☐ HMO ☐ PPO ☐ Medicare/Medicaid ☐ Tricare ☐ No Insurance

Primary insurance name: _____ Subscriber ID#: _____ Group/Policy #: _____

Secondary insurance name: _____ Subscriber ID#: _____ Group/Policy #: _____

2 Provider Practice

Prescriber Name: _____ **Specialty**: _____

Practice Name: _____ Office Contact Name: _____

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

Phone # 1: _____ Phone # 2: _____ Fax #: _____ Email: _____

Prescriber NPI #: _____ Group NPI #: _____ Tax ID #: _____

Alternative Office Contact Name: _____ Alternative Office Contact Phone #: _____ Alternative Office Contact Email: _____

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 Form.

HCP Name: _____ **Signature:** _____ **Date:** ___/___/_____

3 Clinical Information

Diagnosis ☐ J45.50 Severe persistent asthma, uncomplicated ☐ Other _____

ICD-10 Code: ☐ J45.51 Severe persistent asthma with (acute) exacerbation

Eosinophil count: _____ Cells/µL Date of test: ___/___/_____

Number of asthma exacerbations (requiring use of systemic corticosteroids and/or hospitalization) in the last 12 months: _____

4 Prescription Information

Rx FASENRA™ (benralizumab) 30 mg/mL solution in a single-dose prefilled syringe administered by subcutaneous injection every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter. Qty: 1 Refill: _____

Did the patient start on a sample? ☐ Yes ☐ No Total number of FASENRA (benralizumab) doses received since start date: _____ Date of last injection/treatment: ___/___/_____

☐ Free Limited Supply
This program assists with delays in access. Contact Access 360 at 1-833-360-4357 for details about the program.

How will you obtain FASENRA?

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

☒ Specialty Pharmacy Provider (SPP)* Specify Name **Hy-Vee Pharmacy Solutions** SPP Fax #: **855.861.4941** ☐ No Preference*

**If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-833-360-4357.*

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 #: _____

Physician NPI #: _____ Street: _____ City: _____ State: _____ ZIP: _____

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 an Rx 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: _____

☐ Dispense as written

Prescriber Signature: _____ **Date:** ___/___/_____

☐ Substitution permitted

5 Patient Authorization

Patient Information

First Name: _____ Last Name: _____ DOB: ____/____/_____
Street: _____ City: _____ State: _____ ZIP: _____
Home Phone #: _____ Mobile Phone #: _____
Email: _____

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 1-833-360-HELP or by mailing a letter requesting such cancellation to 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 below, unless a shorter period is required by state law.

Communication Preference: ☐ Email ☐ Text ☐ Both†
(I understand that AstraZeneca can send me text messages generated by an automated dialer if I provide my mobile number and that text messaging rates may apply. I also understand that consent is not required to make a purchase).

†*Not Required*

Which best describes you? ☐ I am a patient ☐ I am a legally authorized representative

Patient Name/Legally Authorized Representative Name

_____

Signature of Patient/Legally Authorized Representative

_____ **Date:** ____/____/_____

☐ By checking the box, you will receive information about your disease and may receive information about other AstraZeneca medicines and services related to your condition. *(Optional)*

By completing this registration, I understand that I may also receive ongoing information and support related to my condition, including treatment information. This may include AstraZeneca or a third party working on AstraZeneca's behalf contacting me by telephone regarding AstraZeneca support programs that may be of interest to me. Information provided by AstraZeneca does not take the place of talking to your health care provider about your treatment or condition. AstraZeneca or third parties working on its behalf will not sell or rent your personal information. If, in the future, you no longer want to receive these materials or calls, or you want to report a medication side effect, please call 1-800-236-9933. Please visit www.azprivacynotice.com to review our Privacy Notice.

Communication Preference: ☐ Email ☐ Text ☐ Both†
(I understand that AstraZeneca can send me text messages generated by an automated dialer if I provide my mobile number and that text messaging rates may apply. I also understand that consent is not required to make a purchase).

†*Not Required*

Once completed and signed, fax this form to **1-833-329-2360.** You may need to provide additional information depending on the type of support requested.

1-833-360-HELP (1-833-360-4357) **1-833-FAX-A360** (1-833-329-2360) **www.FasenraResources.com**

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