

# Application for Free AstraZeneca Medicines: **SYNAGIS® (palivizumab)**

PO Box 898, Somerville, NJ 08876



## **How to Complete this Application:**

1. Review the information on this page carefully and keep it for your records.
2. Complete pages 3 and 4 of the application, including parent/caregiver signature.
3. Gather the required documentation listed on page 2.
4. Mail or fax the completed application and required documentation following the instructions on the next page.

## **What are the AZ&Me Prescription Savings Programs?**

- The AZ&Me Prescription Savings Programs (the Program) are a group of programs offered by AstraZeneca that allow your patients to get free medicines if they qualify. It is neither a government program nor an insurance plan
- Patients who qualify may receive free AstraZeneca medicines for up to 1 year

*The Program can be changed or stopped by AstraZeneca at any time or for any reason.*

## **Does your patient qualify for the Program?**

Patients may qualify for the Program if:

- ✓ They are a US Citizen, or a Green Card or Work Visa holder
- ✓ The patient's household meets certain income limits
- ✓ **And one** of the following applies:
  - The patient does not have prescription drug coverage that helps pay for SYNAGIS
  - The patient has insurance coverage but has had an appeal for SYNAGIS coverage denied by their insurance company

The Affordable Care Act has created a marketplace of Health Insurance Exchanges where uninsured individuals and families are able to purchase healthcare coverage, the cost of which may be subsidized for qualified enrollees. More information about these plans can be found at [www.healthcare.gov](http://www.healthcare.gov).

**Please review the checklist on the next page to ensure that your application is complete and ready for submission.**

## AZ&Me Prescription Savings Program Application Checklist

The following items **must** be submitted by mail or by fax to complete your application, even if you have completed the application online. Keep this page for your records.

### Send **ALL** the following **TOGETHER**:

- A completed application, signed and dated by parent/caregiver
- Copy of insurance card (for insured patients only)
- Proof of household income (include only **one** of the following):
  - A copy of last year's federal income tax returns for yourself, spouse, and dependents
  - All income statements from jobs last year (W-2 or 1099)
  - A paystub dated within the last 3 months
  - Current Social Security Income Yearly Benefits Statement
  - **If current household income is zero**, a letter explaining your financial situation from a family member, healthcare provider, or yourself
- Documentation of a denied appeal to the applicant's insurance company for SYNAGIS® (palivizumab) coverage. Please also include documentation of the submitted appeal. (Insured patients only)

Please note: SYNAGIS may be shipped for patients who appear eligible for the AZ&Me Prescription Savings Program prior to receipt of Proof of Income documents. Proof of Income and/or insurance appeal and denial documents must be provided to AZ&Me in order to be eligible for additional SYNAGIS shipments.

**Please do not send your medical records or Statement of Medical Necessity form with your application.**

**MAIL** your completed application and required proof of income documentation to:

**AZ&Me Prescription Savings Program**

**PO Box 898**

**Somerville, NJ 08876**

**Or**

**Your doctor's office may FAX** your completed application and required documentation, with a fax cover sheet to **855-686-8795**.

### Important Information About Your Application

Information provided to us will be used to determine possible eligibility for help from another program such as Medicaid. You may be required to submit documentation supporting that you do not qualify for other prescription assistance.

**Prescription Information**

**PATIENT INFORMATION:** Please print clearly in **blue or black ink**.

Name: \_\_\_\_\_  
*First Middle Initial Last*

Parent or Caregiver Name: \_\_\_\_\_  
*First Middle Initial Last*

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_\_) \_\_\_\_\_ E-Mail: (\_\_\_\_\_) \_\_\_\_\_

Multiple Birth?  Yes  No Patient Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION:**

Prescriber Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DEA: \_\_\_\_\_ NPI: \_\_\_\_\_ State License Number (SLN): \_\_\_\_\_

Office Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Practice Name: \_\_\_\_\_ Office Hours: \_\_\_\_\_

**Program Eligibility Information:** Please print clearly in **blue or black ink**.

Patient Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Parent/Caregiver Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_, if available (*used for eligibility purposes only*)

Green Card Number: \_\_\_\_\_ Work or Student Visa Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**INCOME:**

What is the total combined household income before taxes? (*Include yourself, all adults, and all dependents*)  
Note: You will need to provide proof of income with your application.

\$ \_\_\_\_\_ Monthly OR \$ \_\_\_\_\_ Yearly

Number of people in your household (include all adults and dependents): \_\_\_\_\_

Number of people in your household under age 18: \_\_\_\_\_

**INSURANCE:**

Does the patient have any form of prescription drug coverage?  Yes  No

If Yes, please check all that apply:  Medicaid  Other Prescription Coverage: \_\_\_\_\_

Name of Insurance Plan: \_\_\_\_\_ Insurance Plan Phone Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**CONSENT:**

**I GIVE** my doctor, AstraZeneca, and the Program administrator and their employees, agents, and contractors, permission to verify my information to make sure it is true and complete; contact me by mail or phone about the Program and about other products, programs, or services that might interest me or for which I may be eligible; contact me in order to ensure that I have received the medicines sent by the Program.

**I PROMISE** that all the information in this application, including all copies of documents proving my income, is true and complete; I am authorized to sign this application; I do not have any assistance or insurance that would help pay for my medicines (other than Medicare Part D, if applicable); I will contact the Program if any of my information about my prescription drug coverage or insurance changes.

**I UNDERSTAND** that the Program will only use my information to decide if I qualify to participate in the Program; administer or improve the Program; communicate with insurance plans, including Medicare Part D plans; share my information with the Centers for Medicare and Medicaid Services.

**I UNDERSTAND** that I may be required to apply for prescription assistance through a government assistance program to maintain eligibility in the Program.

**I UNDERSTAND** that I can call 1-800-292-6363 at any time to withdraw from the Program; cancel my permission to use my information and withdraw from the Program; get a copy of the AstraZeneca Privacy Notice.

**I UNDERSTAND** that the Program can request more information from me at any time; AstraZeneca can change or stop the Program at any time or for any reason.

**I UNDERSTAND** that once my information has been disclosed to my doctor, federal privacy laws may no longer restrict its use or disclosure, but the Program will only use my information as described in this form.

**I MAY** refuse to sign this authorization form and if I refuse, my eligibility for health plan benefits and treatment by my health care provider will not change, but I will not have access to the Program.

**I GIVE** the Program, and the Program administrators, permission to contact the person named below with follow-up questions about my application (this only applies if someone completed this application for you).

This authorization form will be effective for 1 year unless it expires earlier by law or I cancel it in writing. I have a right to receive a copy of this form after I have signed it.

**Signature of Parent or Caregiver**

X \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (MM/DD/YYYY)

