

# Application for Free AstraZeneca Medicines:

PO Box 898, Somerville, NJ 08876



AstraZeneca Prescription Savings Program

## How to Complete this Application:

1. Review the information on this page carefully and keep it for your records.
2. Complete pages 3, 4 and 5 of the application.
3. Gather the required documentation listed on page 2.
4. Mail or fax your 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 you to get free medicines if you qualify. It is neither a government program nor an insurance plan
- If you qualify, you may get free AstraZeneca medicine for up to 1 year, depending upon the Program in which you are enrolled. AstraZeneca will send you an application for renewal once your enrollment ends
- Your medication may be sent to your home or to your doctor's office
- Most medicines are sent in a 90-day supply

## Who is AstraZeneca?

- AstraZeneca is a company that makes prescription medicines
  - AstraZeneca has offered prescription savings programs to people who qualify since 1978
- The Program can be changed or stopped by AstraZeneca at any time or for any reason.*

## Do you qualify for the Program?

You may qualify for the Program if:

- ✓ You are a US Citizen, or a Green Card or Work Visa holder
- ✓ You meet certain household income limits  
(visit [www.azandme.com](http://www.azandme.com) or call **1-800-AZandMe** for details)
- ✓ **And one** of the following applies:
  - You do not have prescription drug coverage that helps pay for your AstraZeneca medicines
  - You participate in Medicare Part D and have spent at least 3% of your total household income on prescription medicines through a Medicare Part D Prescription Drug Plan during the current year
  - You are requesting assistance with a medication that is covered under Medicare Part B and you have spent at least 3% of your total household income on prescription medicines through your Medicare benefit during the current year

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 you and your prescriber  
*Blank applications can be found on [www.azandmeapp.com](http://www.azandmeapp.com). If you are applying for assistance with SYNAGIS® (palivizumab), please use the AZ&Me Application for SYNAGIS. If you are applying for one of the following products, please use the AZ&Me Application for Specialty Products: CALQUENCE® (acalabrutinib), FASENRA™ (benralizumab), FASLODEX® (fulvestrant), IMFINZI® (durvalumab), IRESSA® (gefitinib), LYNPARZA® (olaparib), TAGRISSO® (osimertinib)*
- The completed prescription on page 3 of this application
- 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 (W2 or 1099)
  - Two current paystubs
  - 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
- If you are a Medicare Part B or Medicare Part D enrollee, please also include:
  - A copy of the front and back of your Medicare Rx card (for Part D) or your Medicare enrollment card (for Part B)
  - A copy of your Medicare Part B and/or Medicare Part D Prescription Drug Plan statement (Explanation of Benefits [EOB]), a pharmacy printout, or a summary document from your pharmacy indicating the amount you have spent for prescriptions in the current calendar year; this total should be at least 3% of your income

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

**MAIL** your completed application, prescription, 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, prescription and required documentation, with a fax cover sheet. For BRILINTA® (ticagrelor): 1-866-801-5480. For FASENRA™ (benralizumab), SYNAGIS® (palivizumab) or IMFINZI® (durvalumab): 1-855-686-8795. For CALQUENCE® (acalabrutinib), FASLODEX® (fulvestrant), IRESSA® (gefitinib), LYNPARZA® (olaparib), or TAGRISSO® (osimertinib): 1-877-239-0867. For all other products: 1-800-961-8323.

**Applications and prescriptions not faxed from the doctor's office will be deemed invalid.**

### 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.

### For Prescription Refills, call 1-800-292-6363

Once you are enrolled in the Program, your prescriptions can easily be refilled by calling our automated phone line 24 hours a day, 7 days a week.

**Questions? Call 1-800-292-6363 or visit [www.azandme.com](http://www.azandme.com)**

**Monday - Friday, 9:00 AM to 6:00 PM ET**

## Prescription Information

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

Social Security Number: _____ - _____ - _____ <small>(This information will only be used to determine eligibility.)</small>	Date of Birth: ____/____/____ <small>(MM/DD/YYYY)</small>
Name: _____ <small>First Middle Initial Last</small>	
Address: _____	City: _____ State: _____ Zip: _____
<input type="checkbox"/> Patient has no current address. (Medication will be shipped to HCP's office)	
Phone: (____) _____	Alternate Phone: (____) _____ E-mail: _____

New Application  Re-enrollment Please note: Medications can not be shipped to Post Office (PO) boxes.

### PRESCRIBER INFORMATION:



This form will replace all previous prescriptions that may have been sent. All fields are required, eg, BRAND NAME, strength, directions for use, quantity, and refills



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

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

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

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

Medication/Strength and Directions:	QTY:	Refills:

**SHIP MEDICATION TO:**  PATIENT  PRESCRIBER\*

*(\*For Prescribers in Ohio ONLY: Pursuant to OAC 4729-5-10, Ohio prescribers must be approved by the Ohio Board of Pharmacy to be a pick-up station)*

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*NY Prescribers must attach a separate prescription in accordance with NY pharmacy law.*

Source ID: \_\_\_\_\_

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

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
*First Middle Initial Last*

If you don't have a Social Security Number you must provide one of the following:

Green Card (Please provide number): \_\_\_\_\_  Work Visa (Please provide number): \_\_\_\_\_

Primary language spoken:  English  Spanish  Other: \_\_\_\_\_

Marital status:  Married  Divorced  Single  Widow/Widower

Disabled (approved by Social Security):  Yes  No

## 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: \_\_\_\_\_ Number of dependents in your household under 18 years of age: \_\_\_\_\_  
*(Include yourself, all adults, and all dependents)*

## INSURANCE:

Do you have any form of prescription drug coverage?  Yes  No If yes, please provide plan name and ID number: \_\_\_\_\_

*If Yes, please check all that apply:*

Employer-furnished or private drug coverage

VA or Military Benefits  Other Prescription Coverage \_\_\_\_\_

Medicare Part A (hospital)  Medicaid State Assistance program for medicines

Medicare Part B (medical) **\*\*if requested medication is covered under Part B, provide copy of Medicare card (front and back)\*\***

Medicare Part D (prescriptions) **\*\*provide copy of Part D card (front and back)\*\***

Extra Help/Limited Income Subsidy

If the requested medication is covered under Medicare Part B or Part D, how much have you spent on prescription medicines through your Medicare benefit during the current year? \$ \_\_\_\_\_

Do you have supplemental (Medigap) coverage?  Yes  No

If so, does your supplemental coverage cover your total out-of-pocket cost for your medication?  Yes  No

## 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 Statement.

**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 healthcare 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 Applicant or Legal Guardian

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

If someone helped you with this application and you want them to answer questions for you, please give us their name and phone number:

*Helper's Name:* \_\_\_\_\_ *Helper's Phone:* ( \_\_\_\_\_ ) \_\_\_\_\_

