AstraZeneca Patient Savings Program
1-833-360-HELP (1-833-360-4357)

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

PATIENT SAVINGS PROGRAM REIMBURSEMENT REQUEST FORM

Please use this form if you are a patient or caregiver requesting post-payment reimbursement of out-of-pocket costs for certain AstraZeneca medications, through a patient savings program. You should only use this form if you have been advised to do so by Access 360, after you have paid the patient responsibility amount (see your enrollment confirmation letter for specific program details).

To request reimbursement, please fax this completed form, along with all required documentation (below), to **1-833-FAX-A360 (1-833-329-2360)**.

All patients must be enrolled in program prior to requesting reimbursement.
All required information must be provided before request can be processed.

Documents Required:
1. This completed Patient Savings Program Reimbursement Request Form **AND**
2. Explanation of Benefits (EOB) listing out-of-pocket expenses; **OR**
   Dated Pharmacy Receipt as proof of payment, including:
   - Prescription number or Rx number, fill date, drug name, strength, product NDC number
   - Pharmacy name, address, and phone number
   - Quantity, price, and/or co-pay amount paid
3. If applicable, dated receipt for administration of a drug where reimbursement may be provided.

Important: All documents submitted must show a breakdown of charges and include an appropriate code describing the product and/or product NDC, if applicable. No bulk billing will be accepted. Any reimbursement request received more than 180 days from the date of service will be denied. Patients who are enrolled in a state or federally funded prescription insurance program are not eligible for this offer. This includes patients enrolled in Medicare Part D, Medicare Part B, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD) programs or TriCare, and patients who are Medicare eligible and enrolled in an employer-sponsored group waiver health plan or government-subsidized prescription drug benefit program for retirees.

PATIENT DETAILS

LAST NAME: ____________________ FIRST NAME: ____________________ DOB: ____________

ADDRESS: ____ GENDER: ☐ Male ☐ Female

CITY: ____________________ STATE: ____________ ZIP: ________ PHONE: ____________

CAREGIVER NAME (IF APPLICABLE): ____

ASTRAZENECA PRODUCT: ____

SAVINGS PROGRAM GROUP #: ____________________ SAVINGS PROGRAM MEMBER ID #: ____________________

I certify that the information provided for this reimbursement request is accurate to the best of my knowledge, and the co-payment or out-of-pocket expenses requested for reimbursement were actually incurred.

PATIENT/GUARDIAN SIGNATURE ____

PHYSICIAN DETAILS

LAST NAME: ____________________ FIRST NAME: ____________________ OFFICE PHONE: ____________

DOCUMENTS

EXPLANATION OF BENEFITS ATTACHED: ☐ Yes ☐ No

DATED PHARMACY RECEIPT ATTACHED: ☐ Yes ☐ No

IF APPLICABLE, DATED RECEIPT FOR ADMINISTRATION OF DRUG ATTACHED: ☐ Yes ☐ No

Fax completed form and required documentation to the reimbursement fax line at 1-833-FAX-A360 (1-833-329-2360).

The facsimile transmission and accompanying documents contain information that is confidential or privileged. This information is intended for the individual or entity named on this transmission sheet. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of content in this faxed information is strictly prohibited. If you received this fax in error, please notify us by telephone **1-833-360-HELP (1-833-360-4357)** so that we can arrange for the return of the original documents to us and the retransmission of them to the intended recipient. Please allow at least 7 to 10 business days to process your request but some requests may take as long as 6 to 8 weeks.

Access 360 provides patients and their providers with access and reimbursement support for AstraZeneca products.

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