

Please complete form, sign, and fax all pages to **1-833-329-2360**. For questions or assistance, please call Access 360, Monday - Friday, 8 AM – 8 PM ET at **1-833-360-4357**.

Services Requested
(check all that apply)

Patient Initiation Services:

- Benefit Investigation with Prior Authorization Research** (Access 360 will research both the pharmacy and medical benefit for your patient, including prior authorization requirements and specialty pharmacy)
- Pharmacy Research and Triage** (Access 360 will determine the specialty pharmacy for the patient and submit the referral. Please note, this is not applicable to Buy & Bill)
- Prior Authorization Follow-up with Appeals Support*** (Access 360 will contact the payer to track the status of the patient's prior authorization)

*Can only complete if patient signs Patient Authorization below.

Additional Services:

- Claims & Billing Support
- Appeals Support

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

1 Patient Information

First Name: _____ Last Name: _____ Patient DOB: ____/____/____ Gender: M F
 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): _____ OK to contact patient? Yes No
 OK to leave a detailed voicemail? Yes No Has the patient received the Patient Welcome Kit? Yes No Communication Preference (choose one): Email Text Both

Patient Authorization

I have read and agree to the Patient Authorization included on Page 2

FASENRA 360 Support Program (Savings Program and Additional Services)

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

★ Patient Signature/Legal Representative _____ MM / DD / YYYY

 Printed Name/Relationship to Patient (if applicable)

★ 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	

3 Provider Information Prescriber Name: _____ Specialty: _____

Practice Name: _____ Phone #: _____ Fax #: _____
 Street: _____ City: _____ State: _____ ZIP: _____
 Authorized HCP Office Staff Name: _____ Authorized HCP Office Staff Phone: _____
 Authorized HCP Office Staff Email: _____ Prescriber NPI #: _____ Tax ID #: _____
 Medicare Provider # (PTAN): _____ Group NPI #: _____ Other Payer-specific Provider #: _____

By signing this form, I certify that (1) I have received the necessary authorization 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.

Authorized HCP Office Staff Name: _____

★ **Authorized HCP Office Staff Signature:** _____ **Date:** ____/____/____

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 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 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 on Page 1, unless a shorter period is required by state law.

FASENRA 360 Support Program

FASENRA Savings Program

The FASENRA Savings Program is designed to facilitate your access to FASENRA. By providing your authorization, you allow your health care providers, insurance companies and pharmacies to use and share your health care information with the FASENRA Savings Program so that you can participate in this savings program. Your health information may be seen by AstraZeneca and companies working on its behalf for this savings program.

Additional Services

I understand that I may also receive ongoing information and support related to my condition which includes, but is not limited to, providing me with educational and promotional materials, services related to my medical condition or therapy such as injection support for self-administration and 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 telephone, email and/or text message regarding AstraZeneca support programs that may be of interest to me. My Information may also be used to perform internal analysis at AstraZeneca. Information provided by AstraZeneca does not take the place of talking to your health care provider about your treatment or condition.

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. 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 Access 360 at One MedImmune Way, Gaithersburg, MD 20878.

I consent to receive marketing and non-marketing calls and texts from and on behalf of AstraZeneca and AstraZeneca’s Access 360, made with an autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Message and data rates may apply. Text STOP to opt out and HELP for help.

AstraZeneca or third parties working on its behalf will not sell or rent your personal information. Please visit www.globalprivacy.astrazeneca.com to review our Privacy Notice.

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

4 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: _____

5 Acquisition Information

Administration Method (choose one): Pre-Filled Syringe (Office-Administered) Pen (Self-Administered) Would like to understand coverage for both administration methods

In-network Specialty Pharmacy Provider (SPP)* (Preferred SPP: _____)

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

Buy & Bill (prescription information does not need to be completed, research Buy & Bill only)

I am unsure/undecided how I will obtain FASENRA (Access 360 will research both SPP and Buy & Bill options)

Place of Administration (choose one): Prescribing Office (Pre-Filled Syringe) Patient Home (Pen) Alternate Site of Care (ASOC)[†] (Pre-Filled Syringe)

Alternate Site of Care (ASOC) Information *ONLY complete this section if the place of administration differs from the prescribing office.*

Administering Practice/Facility: _____ Administering Physician Name: _____

Phone #: _____ Fax #: _____ Site Tax ID: _____

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

Medicare Provider # (PTAN): _____ Other Payer-specific Provider #: _____

[†]An ASOC is a place of administration that differs from the prescribing office. Alternate sites of care include a Hospital-based Outpatient Department (HOPD), an Alternate Injection Center (AIC), or a physician's office that differs from the prescribing office. Access 360 **will not triage** or communicate benefit investigation results or script to the ASOC listed. Access 360 **will only** confirm that the ASOC is in-network.

6 Prescription Information

Rx FASENRA® (benralizumab)

What is your **primary** choice?

FASENRA® (benralizumab) 30 mg/mL single-dose prefilled syringe
Office-Administered (10-digit NDC: 0310-1730-30)

FASENRA Pen™ (benralizumab) 30 mg/mL single-dose autoinjector
Self-Administered (10-digit NDC: 0310-1830-30)

Please send alcohol wipe and sterile gauze to patient

Has this patient started therapy? Yes No

If yes, how many doses has the patient received? _____

Loading Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 4 weeks for 3 doses

Quantity: 1 Refills: _____

Maintenance Dose 30 mg/mL solution in a single dose administered by subcutaneous injection once every 8 weeks

Quantity: 1 Refills: _____

Known Allergies: _____

Last Injection Date: ____/____/____

If primary choice is not covered, what is your **secondary** choice?

FASENRA® (benralizumab) 30 mg/mL single-dose prefilled syringe
Office-Administered (10-digit NDC: 0310-1730-30)

FASENRA Pen™ (benralizumab) 30 mg/mL single-dose autoinjector
Self-Administered (10-digit NDC: 0310-1830-30)

Please send alcohol wipe and sterile gauze to patient

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 FASENRA.

FASENRA® (benralizumab)

Quantity: 1

Dose Instructions: _____

Please read Prescriber Authorization on Page 4 before signing.

Prescriber Name: _____ **NPI #:** _____ **State License #:** _____

Prescriber Signature: Dispense as written _____ **Date:** ____/____/____

Prescriber Signature: Substitution permitted _____ **Date:** ____/____/____

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.

Prescriber Authorization

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 on Page 3, 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 a diagnosis consistent with an FDA-approved indication for FASENRA 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).

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