Denied Patient Savings Program Cover Sheet

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

Instructions for Use:

- Please use this Cover Sheet to enroll a patient in the Denied Patient Savings Program after his/her prior authorization (PA) appeal has been denied
- Fax the completed application to Diplomat Specialty Pharmacy at 1-866-376-1448. Complete application **must** include:
  - ☐ This form, completed and signed
  - ☐ The original prescription **or** original FASENRA Access 360 Enrollment Form
  - ☐ Copies of the PA denial **and** PA appeal denial
- **Patient enrollment will be delayed** if the completed form, prescription, and denial letters are not all sent at the same time
- Note: If you had intended to Buy & Bill for this patient, please include a new prescription and indicate the date the original PA was submitted
- You will be notified that the patient meets program requirements within 2 days of receipt of a **complete** application

1 Patient Information

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

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

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 Prescriber Information

Prescriber Name: _____ Specialty: _____

Practice Name: _____ Office Contact Name: _____

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

Phone # 1: _____ Phone # 2: _____

Fax #: _____ Email: _____

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 AstraZeneca 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 ICD-10 Code: ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ Other _____

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 FASENRA History

Date of Original Prescription/Prior Authorization Submission Date (Buy & Bill only): _____

Number of Previous FASENRA Doses: _____ Date of Last FASENRA Dose: _____

Once completed and signed, fax this form with the original prescription and copies of the PA denial and PA appeal denial to 1-866-376-1448.

For questions about the Denied Patient Savings Program, contact Diplomat Specialty Pharmacy at **1-877-977-9118 x48606**.

For all other questions, contact Access 360 at **1-833-360-HELP** (1-833-360-4357).

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