Denied Patient Savings Program Cover Sheet

Fasenra® (benralizumab) Subcutaneous injection 30 mg

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 Denied Patient Savings Program at 1-833-329-2360. Complete application **must** include:
  - ☐ This form, completed and signed
  - ☐ The original FASENRA Access 360 Enrollment Form including completed Prescription Information
  - ☐ Copies of the PA denial **and** PA appeal denial
- **Patient enrollment will be delayed** if the completed form, FASENRA Access 360 Enrollment Form 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
- Program support includes periodic Benefits Investigation to identify a potential change in coverage. If a change in coverage is identified, you will be contacted to initiate a new PA for your patient. If the PA is approved, your patient will transition to coverage via their insurance benefits

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 Medical Insurance Name: _____ Subscriber ID #: _____ Group/Policy #: _____

Secondary Medical Insurance Name: _____ Subscriber ID #: _____ Group/Policy #: _____

Pharmacy 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:** ___/___/_____

Once completed and signed, fax this form along with the FASENRA Access 360 Enrollment Form and copies of the PA denial and PA appeal denial to **1-833-329-2360**.

For questions about Denied Patient Savings Program contact Access 360 at **1-833-360-4357**.

Patients in the Denied Patient Savings Program will receive FASENRA through Diplomat Specialty Pharmacy.
For questions regarding order status, contact Diplomat at **1-877-977-9118 x48606**.

AstraZeneca