ASTRAZENECA FOUNDATION

Patient Assistance Program

Instructions:

The AstraZeneca Foundation Patient Assistance Program (PAP) provides access to AstraZeneca medications for qualified patients. Qualifications are determined according to guidelines established by the AstraZeneca Foundation and in accordance with federal guidelines. The AstraZeneca Foundation and its authorized agents reserve the right at any time, and for any reason, to request additional information and to suspend, discontinue, or otherwise revise the aid or assistance provided under the PAP which may include removing products from the PAP.

In order to qualify for the PAP, patients must not be receiving or must not be eligible to receive prescription drug coverage through any government program (such as Medicaid, Medicare Supplemental, State Assistance Programs, etc.), or have drug coverage under private insurance or have any other means to pay for medication. This is a voluntary program.

Return completed applications to:

AstraZeneca Foundation Patient Assistance Program
PO Box 66551
St. Louis, MO 63166-6551

Enrollment in the PAP is for one (1) year. A reminder and application for renewal will be sent automatically to the patient prior to the renewal date. Call **(800) 424-3727** for questions regarding the PAP or visit our website at **www.astrazenca-us.com/drugassist/**

Checklist for Patient:

Before sending your application, please make sure you have completed the following:

- ☐ Complete the Patient Information section. The application and any information included with your application will be returned to you if the information is incomplete. This may cause a delay in processing your application.
- ☐ Attach **copies** of proof of income for you and all dependent persons in the household. Acceptable documents include:
  - > Federal Income Tax (form 1040, 1040A or 1040EZ) **OR**
  - > Federal Income Tax form schedule 1099 **OR**
  - > Yearly benefits statement (SSA 1099, award letter or 4506T)
- ☐ Attach copy of Medicare card (if over age 65).
- ☐ Non-US citizens must provide a US-Green Card number.
- ☐ Sign and date the application. (Original signature required.)

Checklist for Health Care Provider:

Before sending your application, please make sure your health care provider has completed the following:

- ☐ Complete the Physician Information and Prescription Information sections. You may also attach a copy of the prescription.
- ☐ Sign and date the application. Original signature is required. The application and any information included with this application will be returned to the patient if this information is incomplete. This may cause a delay in processing your patient's application.

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* Please type or print legibly
* Do not send checks, cash or money orders with application. **There is no charge for your medication.**
* Be sure to complete all information.

Questions? Call 1-800-424-3727

Patient Information

First Name: _____MI_____Last Name:_____

SSN or Green Card #:_____ DOB:_____ Phone:_____

Address:_____ Apt #: _____

City:_____ State: _____ Zip: _____

U.S. Resident ☐ Yes ☐ No

Number of dependents in household (including self) 1 2 3 4 5 6 7 *(circle one)* ☐ Male ☐ Female

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list:

_____

_____

Please list any medications you are currently taking:

_____

_____

Financial Information

List all sources of gross monthly income. Attach copies of proof of income for you and all dependent persons in the household. Acceptable documents include 1040, 1040A, 1040EZ, 1099, SSA1099, benefits award letter or 4506T.

	Total $ Value	Monthly Interest/Earnings from Assets		Monthly Household
Stocks/Bonds/CDs	$ _____	$ _____	Salary/Wages	$ _____
Checking/Savings	$ _____	$ _____	Pension	$ _____
IRA	$ _____	$ _____	Social Security	$ _____
Annuities	$ _____	$ _____	Disability	$ _____
Other	$ _____	$ _____	Unemployment	$ _____
Please specify:_____			Alimony/Child Support	$ _____
TOTAL($):	$ _____	$ _____	TOTAL($):	$ _____

Insurance Information

Private Insurance	Y ☐	N ☐	Medicare A (Please attach copy of Medicare card)	Y ☐	N ☐
Prescription Drug Coverage	Y ☐	N ☐	Medicare B (Please attach copy of Medicare card)	Y ☐	N ☐
Medicaid	Y ☐	N ☐	VA or Military Benefits	Y ☐	N ☐

Have you applied for Medicaid in the past and been denied? Y ☐ N ☐

(If so, please attach copy of Medicaid denial.)

Consent to Disclosure of Information

I hereby consent to allow the AstraZeneca Foundation and my physician to supply this information to any participating pharmacist and to any third party engaged to assist the AstraZeneca Foundation in the administration of the AstraZeneca Foundation Patient Assistance Program (PAP). I understand that this information will be used by AstraZeneca solely to determine my eligibility for participation in the PAP and that the AstraZeneca Foundation reserves the right at any time and for any reason to request additional information. By signing below I verify that the information in this application, including all copies of income documentation, is complete and accurate and that I am authorized to sign this application. I also verify that I have no other coverage for my prescription medications provided through the AstraZeneca Foundation, including Medicaid, Medicare or other public or private assistance programs. I understand that the Foundation has the right to verify my eligibility, including the right to audit any information provided. I also understand that the Foundation has the right to contact me directly and to confirm receipt of medications, and to revise, change, or terminate this program at any time. I understand that I may revoke this consent and withdraw from participation in the PAP at any time by calling 1-800-424-3727.

Patient's or Legal Guardian's Signature _____ **Date** _____

Shipping Information

Please indicate shipping address if different than patient address.

SSN or Green Card #:_____Patient Name:_____

C/O:_____

Shipping Address:_____ Apt#_____

City:_____ State:_____Zip:_____

Physician Information

Please Print

PhysicianName:_____

Address:_____

City:_____ State:_____Zip:_____

DEA#:_____ Phone:_____

Prescription Information

Have your physician complete the following information or attach an original prescription from your physician.

All prescription information below must be completed by physician in order to process prescription.

Valid for AstraZeneca products only

Date:_____

Product Name:_____ Strength:_____

Directions:_____

Quantity: 90-day supply Refills: **1 2 3 4 5**

*Note: Product will be dispensed in stock bottles to nearest possible quantity.

Physician's Signature:_____ _____

Substitution Permitted Do Not Substitute

*Please note that FASLODEX® (fulvestrant injection), ZOLADEX® (goserelin acetate implant) and SEROQUEL® (quetiapine fumarate) will be shipped to the physician's office. All other products will be shipped to the patient's address unless otherwise specified.

*Medication will be sent in a 90-day supply; therefore, prescriptions should reflect a 90-day supply of medication for each product. Exceptions to this 90-day supply are as follows:

> PULMICORT RESPULES® (budesonide inhalation suspension) must indicate whether the product is to be administered once or twice daily and may be written for a 30-day , 60-day or 90-day supply.

> SEROQUEL® (quetiapine fumarate) may be written for a 30-day, 60-day or 90-day supply.

> ZOLADEX® (goserelin acetate implant) may be written for either 1 dose of the 3.6 mg depot or 1 dose of the 10.8 mg depot.

*Quantities for all other products may be obtained by calling (800) 424-3727.