How to order IRESSA and TAGRISSO

INSTRUCTIONS

AstraZeneca Access 360™

1. Order Form (to submit a prescription through a Specialty Pharmacy Provider [SPP])

- Complete the Order Form and ensure all sections are complete for Patient, Insurance, Healthcare Provider, and Prescription
- Include information or a copy of all patient insurance cards, such as medical and pharmacy cards
- The patient name, dose, quantity, refills, diagnosis code, and original prescriber signature and date are required for the prescription to be filled
- Select preferred SPP you would like to fill the prescription. Check the "No Preference" box for randomized submission based on a patient's insurance coverage

2. Patient Authorization Form (for Access 360 and Field Reimbursement Manager support)*

- Have your patient read, complete, and sign the authorization form
- Remember to provide a copy of the signed and dated form to your patient
- Your patient can also complete the authorization form online at www.MyAccess360PAF.com

3. Submit

- Fax the completed Order Form and Patient Authorization Form to AstraZeneca Access 360 at **1-844-FAX-A360 (1-844-329-2360)**
- Watch for communications from Access 360 or your selected SPP regarding your patient's prescription
- You may submit a prescription to an SPP directly

1-844-ASK-A360
(1-844-275-2360)
Monday through Friday,
8 AM to 8 PM ET.

1-844-FAX-A360
(1-844-329-2360)

www.MyAccess360.com

Access360@AstraZeneca.com

*This completed form is required from Access 360 patient support but not necessary for the patients to access IRESSA or TAGRISSO.

IRESSA® gefitinib

TAGRISSO® osimertinib

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Order Form | ☐ IRESSA® (gefitinib) ☐ TAGRISSO® (osimertinib)

Please complete the entire Order Form and fax it to Access 360™ at **1-844-FAX-A360 (1-844-329-2360).**

PATIENT INFORMATION

Name _____ Diagnosis Code _____

Gender ☐ M ☐ F Date of Birth (MM/DD/YYYY) _____ Primary Language _____

Phone _____ Okay to leave message? ☐ Yes ☐ No

Address _____ City _____ State _____ Zip _____

E-mail _____

Family/Caregiver Name _____ Relationship to Patient _____

Family/Caregiver Phone _____ Family/Caregiver E-mail _____

INSURANCE INFORMATION

☐ Copy of medical card ☐ Copy of pharmacy card ☐ No insurance

Primary Insurance Provider _____ Primary Insurance Phone _____

Cardholder Name (if not patient) _____ Date of Birth (MM/DD/YYYY) _____

Group # _____ Policy # _____ BIN/PCN # _____

Secondary Insurance Provider _____ Secondary Insurance Phone _____

Cardholder Name (if not patient) _____ Date of Birth (MM/DD/YYYY) _____

Group # _____ Policy # _____ BIN/PCN # _____

Pharmacy Insurance Provider _____ **Pharmacy Insurance Phone** _____

Cardholder Name (if not patient) _____ Date of Birth (MM/DD/YYYY) _____

Group # _____ Policy # _____ BIN/PCN # _____

HEALTHCARE PROVIDER INFORMATION

Provider Specialty _____ Prescriber Name _____

Office Name _____ Office Contact _____ Office Phone _____

Office Fax _____ Office E-mail _____

Office Address _____ City _____ State _____ Zip _____

NPI # _____ Tax ID # _____ State License # _____

DEA # _____ Medicare/Medicaid Provider # _____ Provider Transaction Access (PTAN) # _____

PRESCRIPTION

Specialty Pharmacy Provider (SPP):

[☐ Accredo ☐ Avella ☐ Biologics ☐ CVS Specialty ☐ Diplomat ☐ US Bioservices ☐ No Preference*]

*If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-844-275-2360.

☐ IRESSA 250 mg tablet Quantity _____ Refills _____

☐ TAGRISSO 80 mg tablet Quantity _____ Refills _____

☐ TAGRISSO Dose adjustment 40 mg tablet Quantity _____ Refills _____

Dose instructions _____

X _____

Prescriber Original Signature

Date _____

Optional Prescription (15-day supply) for eligible patients to support access to prescribed treatment if there is a delay in determining whether prescription coverage is available

☐ IRESSA 250 mg tablet

☐ TAGRISSO 80 mg tablet

☐ TAGRISSO Dose adjustment 40 mg tablet

Dose instructions _____

X _____

Prescriber Original Signature

Date _____

I authorize AstraZeneca's 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 above, 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, assisting in initiating or continuing therapy.

Each practitioner is solely responsible for ensuring the accuracy of the information submitted. New York prescribers must submit a state-approved prescription document with this completed form. Ohio prescribers should note that only one prescription per form is allowed. Please send additional prescriptions separately.

IRESSA® (gefitinib) and TAGRISSO® (osimertinib) Patient Authorization Form

AstraZeneca Access 360™ is an optional program provided by AstraZeneca for patients, their caregivers, family, and providers. Access 360 can help you understand your coverage and financial obligation for AstraZeneca medicines and provide you with resources to help with treatment and payment for treatment.

By signing below, I authorize my healthcare providers 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 healthcare plan benefits, and any other information bearing on my health. My Information may be used to verify, investigate, and assist with coordination of coverage for AstraZeneca products; track my prescription as requested by my physician; contact me about patient assistance programs; and perform internal analysis at AstraZeneca to better meet patient needs. 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 mailing a letter requesting such cancellation to 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.

Patients are entitled to a signed copy. *This authorization expires two (2) years from the date signed below, unless a shorter period is required by state law.*

FOR COMPLETION BY PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

Name (First Last): _____

DOB: _____ E-mail Address: _____

Mailing Address Street/Apt: _____

City/State/Zip: _____

Relation to Patient: ¨ Patient ¨ Legally Authorized Representative of Patient

Patient or Legally Authorized Representative Signature: _____ Date:_____

OPTIONAL:

Enrollment in IRESSA Connects or TAGRISSO Connects, and other IRESSA or TAGRISSO health-related information

☐ **By checking this box and completing the information above**, I certify that I am at least 18 years old and would like to receive information about my prescribed therapy, IRESSA or TAGRISSO, and related health information from AstraZeneca (AZ) and IRESSA Connects or TAGRISSO Connects.

By completing this registration, I understand that I may also receive ongoing information and support related to my condition, including treatment information. Information sent by AZ does not take the place of talking to your healthcare provider about your treatment or condition. AZ, or third parties working on its behalf, will not sell or rent your personal information. If in the future you no longer want to receive these materials, or to report a medication side effect, please call 1-800-236-9933. Please visit **www.azprivacynotice.com** to review our Privacy Notice.

Please ensure this Patient Authorization Form is completed and fax it to Access 360 at 1-844-FAX-A360 (1-844-329-2360).

AstraZeneca Access 360™