



ASTRAZENECA

Patient Assistance Program

Patient Application

To apply for the AstraZeneca Patient Assistance Program (PAP), read the following instructions. Please complete and sign the application, and mail it to the address at the bottom of this page. Include the appropriate income documentation listed below and an original, signed prescription from your physician. Incomplete applications will cause a delay in processing, so if you need assistance filling out this application, please contact the AstraZeneca PAP at 800-424-3727.

INSTRUCTIONS:

The AstraZeneca PAP is a voluntary program that provides access to AstraZeneca medications for qualified patients. Qualifications are determined according to guidelines established by the AstraZeneca PAP and in accordance with federal guidelines.

The AstraZeneca PAP 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 or changing eligibility requirements.

TO QUALIFY:

Patients must meet qualifying income and **must not receive prescription drug coverage** through a government program or private insurance such as:

- Medicaid
- Medicare (Part B)
- Medicare Prescription Drug Program (Part D)
- Medicare Supplemental Drug Coverage
- State-sponsored prescription drug assistance programs (SPAP, SCHIP, PACE, etc.)
- Employee, union, or retirement program drug coverage
- Military or veteran benefits
- Other private drug coverage program

If a patient appears to be eligible for the PAP and also appears to be eligible for federal or state government programs or assistance, the AstraZeneca PAP will provide one-on-one education and counseling to assist that patient through the application process for those federal and state programs (subject to any legal requirements). During this time, the patient will be temporarily enrolled in the PAP and will be able to receive a minimum of one 90-day supply of the medicine(s) requested on this application while completing the application process for federal or state **programs and** awaiting confirmation of acceptance into such programs.

ALL PATIENTS MUST PROVIDE THE FOLLOWING:

1. **Completed application form** signed by patient
 2. **Patient's original prescription** signed by physician
 3. **Copies of proof of income** for patient and dependent persons in the household
- Acceptable documents include the following:
- Federal Income Tax Form (1040, 1040A, or 1040EZ, 1040X, 1722, 8453, 8879, 1099INT)
 - Yearly Benefits Statement (SSA1099 or 4506T)
 - IRS Telefile Worksheet
 - W2 Tax Statement
 - Social Security, Pension, or Railroad Retirement Statements (SSA-1099, 4506T)
 - Statements of interest, dividends, or other income (1099-INT, 1099, 1099T, 1099-DIV)
- **If the patient did not file a federal income tax return** for the prior year, he/she must complete and sign the *IRS Income Documentation* section on the other side of this form and include copies of all other proof-of-income documents.
- **Non-US Citizens** must provide a valid US Green Card Number or a copy of the confirmation letter from the government stating that the patient has applied for a US Green Card.
- **If the patient cannot provide any proof-of-income documents**, or if the patient needs help with the application, please call us at 800-424-3727.

ALL HEALTH CARE PROVIDERS MUST PROVIDE THE FOLLOWING:

1. The original signed prescription
2. Completed physician section


Important Shipping and Prescribing Instructions


- 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 may be written for a 30-day, 60-day, or 90-day supply. ZOLADEX may be written for either 1 dose of the 3.6 mg depot or 1 dose of the 10.8 mg depot.

- For INJECTABLES, the physician's office or the patient must call for their MONTHLY refill 7-10 days PRIOR to the patient's appointment with the physician.
- Quantities for all other products may be obtained by calling 800-424-3727.

RETURN COMPLETED APPLICATIONS TO:

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

 For questions regarding the PAP, call 800-424-3727, or

 visit our Web site at www.astrazeneca-us.com/drugassist/

Enrollment in the PAP is for up to one (1) year. A reminder and application for renewal will be sent automatically to the patient prior to the renewal date.

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- Please print clearly and in black or blue ink.
- Do not send checks, cash, or money orders with application.
- Be sure to complete all information.
- **Questions? Call 800-424-3727.**



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Section 1 - Health Care Provider Information *To be completed by the practitioner who writes the prescription.*

Physician Name:	DEA/State License #:	Phone: ()	
		Fax: ()	
Address:	City:	State:	ZIP:

Please attach an original prescription signed by your physician

Section 2 - Patient Information

Patient Name:	Social Security/Green Card Number:		
Street Address:	Date of Birth: / /		
City:	State:	ZIP:	Phone: ()
Are you allergic to any medications? Yes <input type="checkbox"/> No <input type="checkbox"/>	Please list any medications you are currently taking:		
If yes, please list: _____			
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Ethnic origin (optional) Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/>		
Primary language spoken (optional): English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			

Enrollment Information

Number of household members (including self): _____	Total yearly income for your household \$ _____	US Resident: Yes <input type="checkbox"/> No <input type="checkbox"/>	Disabled: Yes <input type="checkbox"/> No <input type="checkbox"/>	Veteran: Yes <input type="checkbox"/> No <input type="checkbox"/>	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>
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IRS Income Documentation

If you did not file a federal tax return for 200__, sign the section below requesting a 4506T IRS form. This form will be used to verify that you in fact did not earn enough income required to file taxes for the above mentioned calendar year.

Signature X _____ Date _____

Prescription Drug Coverage/Insurance Information

Employer/private health coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/private drug coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part B <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part D <input type="checkbox"/> Yes <input type="checkbox"/> No
VA or Military Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No	State Patient Assistance Program (SPAP, SCHIP, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No

Have you applied for Medicaid in the past and been denied? Yes No *(If yes, please attach copy of Medicaid denial letter.)*

Consent for Disclosure of Information

I hereby consent to allow the AstraZeneca Patient Assistance Program and my physician to supply this information to any participating pharmacist and to any third party engaged to assist the AstraZeneca Patient Assistance Program in the administration of the program. I understand that this information will be used by the AstraZeneca Patient Assistance Program solely to determine my eligibility for participation in the PAP and to administer the program (e.g., communicating with insurers including Medicare Part D if Medicare eligible), and that the AstraZeneca Patient Assistance Program reserves the right at any time and for any reason to contact me and to request additional information. If you would like a copy of the AstraZeneca Privacy Statement, please call 1-800-424-3727.

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 Patient Assistance Program, including Medicaid, Medicare (Part B or Part D), or other public or private assistance/insurance programs. I understand that the AstraZeneca Patient Assistance Program has the right to verify my eligibility, including the right to audit any information provided. I agree that I will contact the AstraZeneca Patient Assistance Program if any of the information regarding prescription drug coverage or insurance changes. I understand and agree that the AstraZeneca Patient Assistance Program has the right to contact me directly regarding the PAP, this application, any products, programs, or services that the AstraZeneca Patient Assistance Program deems may be of interest or value to me and to confirm receipt of medications. I also understand that the AstraZeneca Patient Assistance Program has the right to revise, change, or terminate this program at any time, and 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:
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