My LOKELMA Support Program | AstraZeneca Access 360™

Enrollment Form

LOKELMA® (sodium zirconium cyclosilicate) 5 g | 10 g for oral suspension

Service Requested (check only those that apply)

☐ Benefit Investigation and Prior Authorization Research ☐ Appeals Support ☐ Affordability Support

To enroll in the AstraZeneca Savings Program,* visit www.lokelmasavings.com
To enroll in the AZ&Me™ Prescription Savings Program (Patient Assistance Program*), visit www.azandmeapp.com
*Eligibility requirements will apply.

Please complete and sign form and fax this page to **1-855-880-5258**.

For questions or assistance, please call My LOKELMA Support Program, Monday through Friday, 8 AM – 8 PM EST at **1-866-494-8080**.

PATIENT INFORMATION

1

First Name: _____ Last Name: _____ Patient DOB: _____/ ____ /_____ Gender: ☐ M ☐ F

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

Preferred Phone #: ☐ Home ☐ Mobile _____ Patient Email: _____

Alternate Contact Name: _____ Relationship to Patient: _____

Alternate Contact Phone #: _____ Patient preferred language (if other than English): _____

Okay to leave a detailed voicemail? ☐ Yes ☐ No Communication Preference: ☐ Email ☐ Text ☐ Both

Patient Authorization

I have read and agree to the Patient Authorization included on page 2, section 5.

_____ / / _____
Patient Signature/Legal Representative MM DD YYYY

_____
Printed Name/Relationship to Patient (if applicable)

Support Program Enrollment

I have read and agree to the Support Program Enrollment included on page 2, section 6.

_____ / / _____
Patient Signature/Legal Representative MM DD YYYY

_____
Printed Name/Relationship to Patient (if applicable)

INSURANCE INFORMATION

2

Please include front and back copies of all medical and pharmacy cards and/or complete this section.

☐ Commercial/Private Insurance ☐ Medicare/Medicaid/TRICARE ☐ No Insurance

	Primary Medical Insurance	Secondary Medical Insurance	Pharmacy Insurance
Insurance Provider			
Insurance Phone #			
Cardholder Name (if not the patient)			
Cardholder DOB			
Policy #			
Group #			
BIN/PCN	X	X	

PROVIDER INFORMATION

3

Prescriber/HCP Name: _____ Specialty _____

Practice Name: _____

Office Name Contact: _____

Address: _____

Phone #: _____ Fax #: _____

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 My LOKELMA Support Program, 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 My LOKELMA Support Program to contact the patient, if not included with this submission to obtain a signed My LOKELMA Support Program Patient Authorization.

HCP Signature: _____ Date: _____

CLINICAL INFORMATION SECTION

4

Diagnosis: _____

ICD-10-CM: _____

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PATIENT AUTHORIZATION

5 I authorize my health care providers (HCPs) and staff, my health plan, and my pharmacies to use and share Protected Health Information (my "Information") with AstraZeneca (including My LOKELMA Support Program) and its affiliates, as well as its contractors ("AstraZeneca"). My Information includes my prescription-related health records, Information about my health care plan benefits, demographic, contact, and any other Information bearing on my health. My Information may be used to verify treatment and payment decisions with my HCPs; investigate and assist with coordination of coverage for AstraZeneca products; coordinate prescription fulfillment and financial assistance; and perform internal analysis at AstraZeneca to better meet patient needs. I understand and agree that AstraZeneca may contact me by mail, email, and telephone. 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 support from the My LOKELMA Support Program. I understand that I may cancel this Authorization at any time by calling 1-866-494-8080 or by mailing a letter requesting such cancellation to My LOKELMA Support Program at 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 receipt of the cancellation. This authorization expires two (2) years from the date signed on page 1, unless a shorter period is required by state law.

SUPPORT PROGRAM ENROLLMENT

6 I understand that I may also receive ongoing information and support related to my condition that includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my therapy or my medical condition and for market research purposes, which includes contacting me to participate in focus groups, surveys, or interviews. This may include AstraZeneca or a third party working on AstraZeneca's behalf contacting me by telephone, email, and/or text message regarding AstraZeneca support programs that may be of interest to me. Information provided by AstraZeneca does not take the place of talking to your health care provider about your treatment or condition.

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. I understand that I may cancel this Authorization at any time by calling 1-866-494-8080. Message and data rates may apply. Text STOP to opt out and HELP for help.

AstraZeneca or third parties working on its behalf will not sell or rent your personal information. Please visit www.globalprivacy.astrazeneca.com to review our Privacy Notice.

AstraZeneca

After you complete and sign the form, fax it to 1-855-880-5258. You may need to provide additional information depending on the type of support requested.

1-866-494-8080 | 1-855-880-5258 | One MedImmune Way, Gaithersburg, MD 20878