

ICD-10-CM:



## **Enrollment Form**



**Service Requested** (check only those that apply)

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

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

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

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

quirements will apply.			at <b>1-866-494-8080</b> .
	PATIENT INFOR	MATION	
First Name: Las	t Name:	Patient DOB:/ / /	Gender: □M □F
		State:	
	•	Patient Email:	
		ient:	
		nguage (if other than English):	
Okay to leave a detailed voicemail?			
Patient Authorization	3 THO COMMUNICATION PROFESSION.	Support Program Enrollment	
	horization included on page 2, section 5.	I have read and agree to the Support Program	m Enrollment included on page 2, section
	/ /		/ /
Patient Signature/Legal Representati	ve MM DD YYYY	Patient Signature/Legal Representativ	e MM DD YYYY
Printed Name/Relationship to Patient (if a	oplicable)		plicable)
			•
	INSURANCE INFO	RMATION	
Please include front and back copi	es of all medical and pharmacy card	ls and/or complete this section.	
☐ Commercial/Private Insurance	☐ Medicare/Medicaid/TRICARE ☐ N	o 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 INFOR	RMATION	
Prescriber/HCP Name:	PROVIDER INFOR	RMATION Specialty	
	PROVIDER INFOR	Specialty	
Practice Name:		Specialty	
Practice Name:Office Name Contact:		Specialty	
Practice Name:Office Name Contact:		Specialty	
Practice Name:  Office Name Contact:  Address:  Phone #:  By signing this form, I certify that (1) I h. Information (as defined by HIPAA) to My dispensing pharmacy(ies) or other entit	Fax #:ave received the necessary authorization to LOKELMA Support Program, including empies, for the purposes of treatment and pay	Specialty	neca, and health care plans for progr necessary authorization to allow M
Practice Name:  Office Name Contact:  Address:  Phone #:  By signing this form, I certify that (1) I ha Information (as defined by HIPAA) to My dispensing pharmacy(ies) or other entit LOKELMA Support Program to contact	Fax #:ave received the necessary authorization to LOKELMA Support Program, including empies, for the purposes of treatment and pay	release the information included on this folloyees, contractors, or affiliates of AstraZer	neca, and health care plans for progr necessary authorization to allow My port Program Patient Authorization







## PATIENT AUTHORIZATION



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



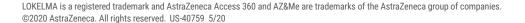
I understand that I may also receive ongoing information and support related to my condition that includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my therapy or my medical condition and for market research purposes, 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.











One MedImmune Way, Gaithersburg, MD 20878