AstraZeneca Access 360™ Enrollment Form

FluMist Quadrivalent
Influenza Vaccine Live, Intranasal

AstraZeneca Access 360™

Services Requested (check only those that apply)

- ☐ **Benefit Investigation**
- ☐ **Prior Authorization:**
  - ☐ Research ☐ Follow-Up
- ☐ **Claims/Authorization Appeal Support**

Please complete form, sign, and fax all pages to **1-844-329-2360**.

For questions or assistance, please call Access 360, Monday through Friday, 8 AM – 8 PM at **1-844-275-2360**.

1 Patient Information

Full Name (First and Last):		Patient Home Phone #:		
DOB (MM/DD/YYYY): / /	Gender: ☐ Male ☐ Female	Patient Mobile Phone #:		
Primary Language: ☐ English ☐ Spanish ☐ Other:		Patient Email Address:		
Street Address:		Alternate Contact:	1)	2)
City:		Relationship to Patient:	1)	2)
State:	ZIP:	Alternate Contact Phone #:	1)	2)

2 Insurance Information

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

☐ No insurance

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

3 Prescriber Information

Prescriber Name:		Practice Name:	
Prescriber Specialty:		Street Address:	
Office Contact Name:		City:	
Phone #:	Fax #:	State:	ZIP:
Email:		Prescriber NPI #:	
Alternate Office Contact Name:		Tax ID #:	
Alternate Contact Phone #:		PTAN:	
Alternate Contact Email:		Other Provider ID (if applicable):	

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 AstraZeneca Access 360 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 AstraZeneca Access 360 to contact the patient or caregiver, if not included with this submission to obtain a signed Patient Authorization.

HCP Name

_____

HCP Signature

_____ **Date:** ____/____/____

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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 AstraZeneca Access 360) 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; coordinate educational nursing support; and perform internal analysis at AstraZeneca to better meet patient needs. I understand and agree that AstraZeneca may contact me by mail, email, telephone, and text. 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 AstraZeneca Access 360 support. I understand that I may cancel this Authorization at any time by calling 1-800-236-9933 or by mailing a letter requesting such cancellation to AstraZeneca Access 360 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 their receipt of the cancellation. This authorization expires two (2) years from the date signed, unless a shorter period is required by state law.

Which best describes you?

☐ I am a patient ☐ I am a legally authorized representative **Relationship to patient:** _____

Communication Preference:

☐ Email ☐ Text ☐ Both

Print Patient Name/Legally Authorized Representative Name

_____

Signature of Patient/Legally Authorized Representative

_____ **Date:** ____/____/____

Once completed and signed, fax this form to **1-844-329-2360**. You may need to provide additional information depending on the type of support requested.

1-844-ASK-A360 (1-844-275-2360) **1-844-FAX-A360** (1-844-329-2360) **www.MyAccess360.com**

Access360@AstraZeneca.com **One MedImmune Way,** Gaithersburg, MD 20878

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