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

For information about 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 ET at **1-844-LOKELMA (1-844-565-3562).**

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 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 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 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.

SUPPORT PROGRAM ENROLLMENT

6 By providing consent, I understand that I may receive ongoing information and support related to my condition which includes, but is not limited to, providing me with educational and promotional materials, information, special offers, and services related to my medical condition or therapy, as well as 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 mail, telephone, email and/or text message regarding AstraZeneca support programs that may be of interest to me. I consent to receive marketing and non-marketing calls and texts from and on behalf of AstraZeneca, made with an auto-dialer or prerecorded voice, at the phone number(s) provided. Message and data rates may apply. My Information may also be used to perform internal analysis at AstraZeneca. I understand that I can refuse to provide this Authorization and that this will not affect my treatment or payment for treatment, insurance coverage, or eligibility for benefits. I understand that my consent is not required or a condition of purchase. 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. Information provided by AstraZeneca does not take the place of talking to your health care provider about your treatment or condition. AstraZeneca will not knowingly collect, use, or disclose personally identifiable information from a minor under the age of 18. If you are under the age of 18, please have your parent, guardian, or healthcare provider request the information on your behalf. 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.

1-844-LOKELMA
(1-844-565-3562)

1-855-880-5258

www.myaccess360.com/lokelma

One MedImmune Way
Gaithersburg, MD 20878