Saphnelo™ SUPPORTS | AstraZeneca Access 360™

Saphnelo™ (anifrolumab-fnia)

DENIED PATIENT SAVINGS PROGRAM COVER SHEET

Instructions for Use:

- Please use this Cover Sheet to enroll a patient in the Denied Patient Savings Program after his/her insurance authorization (prior authorization, precertification, predetermination) appeal has been denied
- Fax this completed application to Denied Patient Savings Program at 1-866-511-2360. Complete application **must** include:
    - ☐ This form, completed and signed
    - ☐ The original SAPHNELO Access 360 Enrollment Form including completed Prescription Information in Section 7 or new prescription
    - ☐ Copies of the initial insurance authorization denial **and** appeal denial
    - ☐ Signed patient authorization (see Section 2 of SAPHNELO Access 360 Enrollment Form). This is not required to complete enrollment into the program but will be **required for subsequent refills**
    - ☐ If your patient did not sign the patient authorization form in Section 2 of the SAPHNELO Access 360 Enrollment Form, he/she can call 1-866-SAPHNELO (1-866-727-4635) to provide verbal patient authorization or visit www.myaccess360paf.com to provide an electronic patient authorization.
- **Patient enrollment will be delayed** if the completed form, SAPHNELO Access 360 Enrollment Form and denial letters are not all sent at the same time
- You will be notified that the patient meets program requirements within 2 days of receipt of a **complete** application
- Program support includes periodic Benefit Investigations beginning at 6 months after enrollment to identify a potential change in coverage. If a change in coverage is identified, you will be contacted to initiate a new Insurance Authorization for your patient. If the insurance authorization is approved, your patient will transition to coverage via their insurance benefits

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DENIED PATIENT SAVINGS PROGRAM COVER SHEET *(cont'd)*

1 Patient Information

First Name: _____ Last Name: _____ Patient DOB: _____

Patient Phone #: _____ Mobile Phone #: _____ Patient Email: _____

Insurance Information

☐ **Please include front and back copies of all medical and pharmacy cards or facesheet**

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

Primary Medical Insurance Name: _____ Subscriber ID #: _____ Group/Policy #: _____

Secondary Medical Insurance Name: _____ Subscriber ID #: _____ Group/Policy #: _____

Pharmacy Insurance Name: _____ Subscriber ID #: _____ Group/Policy #: _____

2 Prescriber Information

Prescriber Name: _____ Specialty: _____

Practice Name: _____ Office Contact Name: _____

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

Phone #1: _____ Phone #2: _____

Fax #: _____ Email: _____

Alternative (ALT) Office Contact Name: _____

ALT Office Contact Phone #: _____ ALT Office Contact Email: _____

Site of Care (if different than Practice Address): _____ Patient Phone #: _____

Mobile Phone #: _____ Patient Email: _____

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

Prescriber Signature

_____ / / _____

Today's Date: MM DD YYYY

Printed Name: _____

Once completed and signed, fax this form along with the SAPHNELO Access 360 Enrollment Form, and other insurance authorization denial documentation to **1-866-511-2360**.

For questions about Denied Patient Savings Program, contact **Access 360** at **1-866-SAPHNELO (1-866-727-4635)**.

Patients in the Denied Patient Savings Program will receive SAPHNELO through Amber Specialty Pharmacy. For questions regarding order status, contact Amber Specialty Pharmacy at **855-896-4865**.

AstraZeneca