WAINUAWay | AstraZeneca Access 360™

ENROLLMENT FORM

WAINUA™ (eplontersen) 45 mg injection for subcutaneous use

PLEASE COMPLETE AND SIGN THE FORM, THEN FAX PAGES 1 AND 3 TO 1-844-329-2360.
For questions or assistance, please call Access 360 at 1-844-2-WAINUA (1-844-292-4682), Monday through Friday, 8 AM – 6 PM ET.

Completion of this form provides the following services:

- Benefits Investigation research
- Prior authorization (PA) follow-up, including tracking status of PA and appeals support, if necessary (Patient Authorization below is required)
- Transfer of prescription* to specialty pharmacy (Section 5A of this form is required)
- Co-pay support for eligible patients (Support Program box below must be checked off)
- Select patient services†

*Free Limited Supply is available for eligible patients (See Section 5B of this form).
†Includes information about the disease state and WAINUA, updates during the insurance approval process, and resources on how to take WAINUA.

1 Patient Information

Patient's (Pt) first name, last name, DOB, street address, city, state, and ZIP code are required and must be filled out by the office.

Pt First Name: _____ Pt Last Name: _____ Pt DOB: ____/____/_____

Pt Street: _____ City: _____ State: _____ ZIP Code: _____

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

Alternate Contact Name: _____

Alternate Contact Relationship to Patient: _____ Alternate Contact Phone #: _____

OK to contact patient? ☐ Yes ☐ No

OK to leave a detailed voicemail? ☐ Yes ☐ No

Preferred Language (If not English): _____

Pt Communication Preference (Select one): ☐ Email ☐ Mobile phone/text ☐ Both

Patient Authorization

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

_____ ____/____/____ _____

Patient/Legal Representative Signature MM DD YYYY Printed Name/Relationship to Patient (If applicable)

WAINUA Support Authorization (Savings Program and Additional Support)

☐ I have read and agree to the Support Program Authorization included on page 2.

If patient is unavailable to sign, they can visit www.azpatientsupport.com or call 1-844-292-4682 to provide authorization.

2 Insurance Information

Complete this section **AND** include front and back copies of **all medical and pharmacy cards.**
If your patient is without insurance coverage or on Medicare and cannot afford their medication, AZ&Me™ may be able to help.
Visit www.azandmeapp.com or call 1-800-292-6363 for more information.

☐ Commercial/private insurance ☐ Medicare/Medicaid/TRICARE ☐ No insurance

	Medical Insurance	Pharmacy Insurance	
Insurance provider			
Insurance phone #			
Cardholder name (If not the patient)			
Cardholder DOB			
Policy #			
Group #			
RxBIN/RxPCN	N/A	RxBIN:	RxPCN:

ENROLLMENT FORM

Patient Authorization

I authorize my health care providers ("HCPs"), my health plan, and my pharmacies, and each of their respective agents, to use and share my Protected Health Information (my "Information") with AstraZeneca and Ionis Pharmaceuticals (including AstraZeneca US Patient Support and Ionis Patient Services) ("AZ/Ionis") and their affiliates, agents, and contractors. 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 WAINUA™ (eplontersen); coordinate prescription fulfillment and financial assistance; coordinate the provision of patient educational support and perform internal analysis at AZ/Ionis to better meet patient needs. I understand and agree that AZ/Ionis may contact me, including by mail, email, telephone and text. I understand that federal privacy laws may not protect my Information once it is disclosed; however, AZ/Ionis agrees to protect my Information by using and disclosing it only for the purposes specified herein. I understand that I can refuse to sign this Authorization and that my refusal 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 AZ US Patient Support/Ionis Patient Services 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 US Patient Support 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 AZ/Ionis's 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.

WAINUA Support Authorization (Savings Program and Additional Support)

By providing consent, I understand that I may receive from AZ/Ionis or their agents, on an ongoing basis, information and support related to my condition and/or therapy including, but not limited to, educational and promotional materials, special offers, and support services. I further understand that I may be contacted by AZ/Ionis or their agents, on an ongoing basis, for market research purposes, including for the purpose of participating in focus groups, surveys, or interviews. I consent to receive marketing and non-marketing communications, including by mail, telephone, email and/or text message from AZ/Ionis or their agents, whether or not 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 AZ/Ionis. 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, and is not 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 Services 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. AZ/Ionis 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.

WAINUA Way | AstraZeneca Access 360™

ENROLLMENT FORM

WAINUA™ (eplontersen) 45 mg injection for subcutaneous use

Pt First Name: _____ **Pt Last Name:** _____ **Pt DOB:** ____/____/____

3 Clinical Information

Select the relevant option(s) below for the ICD-10-CM diagnosis code:

☐ E85.1 Neuropathic heredofamilial amyloidosis (transthyretin-related [ATTR] familial amyloid polyneuropathy)

☐ Other: _____

4 Prescriber Information

By completing 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, including AstraZeneca US Patient Support/Ionis Patient Services, including employees, contractors, or affiliates of AstraZeneca and Ionis Pharmaceuticals, 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.

Prescribing Provider Name: _____ Specialty: _____

Practice Name: _____ Office Contact Name: _____

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

Office Phone #: _____ Office Fax #: _____ Email: _____

Prescribing Provider NPI #: _____

Other Provider ID (if applicable): _____

5 Prescription Information

(A) ONLY complete this section if using Orsini Specialty Pharmacy to fill the prescription.

Rx: WAINUA™ (eplontersen) injection, 45 mg/0.8 mL single-dose autoinjector

10-digit NDC: 0310-9400-01

Dose instructions: _____

Quantity: _____ Refills: _____ Other: _____

(B) OPTIONAL: Free Limited Supply (FLS) Request

☐ Provides a free, short-term supply of WAINUA for eligible patients who are denied immediate access or are awaiting insurance coverage determination.

Rx: WAINUA™ (eplontersen) injection, 45 mg/0.8 mL single-dose autoinjector

Dose instructions: _____

Quantity: 1 single-dose autoinjector

Please note that FLS is a temporary program and does not replace existing affordability programs that may be more appropriate for long-term access barriers.

Please read the **Prescriber Authorization** on page 4 before signing below.

Prescriber First Name: _____ Prescriber Last Name: _____

Prescriber NPI #: _____ State License #: _____

_____ ____/____/____

Prescriber Signature: Dispense as written MM DD YYYY

_____ ____/____/____

Prescriber Signature: Substitution permitted MM DD YYYY

Please complete and sign the form, then fax pages 1 and 3 to 1-844-329-2360.

ENROLLMENT FORM

Prescriber Authorization

I authorize the Access 360 program to convey the attached prescription on my behalf to the pharmacy chosen on page 3 and to receive information on the status and related matters. By signing, I certify that the medicine prescribed on this form is medically necessary based on my independent medical judgment, and I have received the necessary authorization to release the information included on this form and other Protected Health Information (as defined by HIPAA) to Access 360, the dispensing pharmacy, or other contractors for the purpose of seeking reimbursement or assisting in initiating or continuing therapy. Each practitioner is solely responsible for ensuring the accuracy of the information submitted.

If requesting Free Limited Supply:

I verify that the information provided on this form is accurate. I understand that the patient must have an FDA-approved diagnosis to be eligible for Free Limited Supply. I also understand I must submit a prescription compliant with my state law. Reimbursement for the cost of the product administered to the patient on the date(s) indicated has not been sought and will not be sought from any source. Additionally, I understand that AstraZeneca/Ionis reserves the right to conduct periodic audits of the records, excluding patient-identifiable data (unless patient authorization is on file with Access 360), of all entities receiving Free Limited Supply. I understand that AstraZeneca/Ionis reserves the right to modify or revoke this program at any time without notice. My signature confirms that this product was provided free of charge to this patient. (Using signature stamp or signing on behalf of the prescriber is not permitted.)

Once completed and signed, fax pages 1 and 3 of this form to 1-844-329-2360. You may need to provide additional information depending on the type of support being requested.

For more information, please contact AstraZeneca Access 360™ at 1-844-2-WAINUA, Monday through Friday, 8 AM – 6 PM ET.

1-844-2-WAINUA (1-844-292-4682)

www.MyAccess360.com

1-844-FAX-A360 (1-844-329-2360)

Access360@AstraZeneca.com

One MedImmune Way, Gaithersburg, MD 20878