Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Healthcare Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.

Rich Sagall, MD
President, NeedyMeds

Clip the card and save

NeedyMeds
NeedyMeds.org

DRUG DISCOUNT CARD

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

Customer Care
1-888-602-2978

This is a drug discount program, not an insurance plan.

NeedyMeds Drug Discount Card
www.needymeds.org

Patient: You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

Pharmacist: Administered by Medical Security Company, LLC, Tucson, AZ.

Pharmacy Help Desk: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

This is a drug discount program, not an insurance plan. Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

Application for Free AstraZeneca Medicines:

Specialty Care Products (Oncology & Respiratory/Immunology Biologics Products) PO Box 222178, Charlotte, NC 28222

AZ&ME™

AstraZeneca Prescription Savings Program

How to Complete this Application:

1. Review the information on this page carefully and keep it for your records.
2. Complete pages 3, 4 and 5 of the application.
3. Gather the required documentation listed on page 2.
4. Mail or fax your completed application and required documentation following the instructions on the next page.

What are the AZ&Me Prescription Savings Programs?

- The AZ&Me Prescription Savings Programs (the Program) are a group of programs offered by AstraZeneca that allow you to get free medicines if you qualify. It is neither a government program nor an insurance plan
- If you qualify, you may get free AstraZeneca medicine for up to 1 year, depending upon the Program in which you are enrolled. AstraZeneca will send you renewal documents as your enrollment end date approaches
- Most medicines will be sent to your home. Some medicines will be sent to your doctor's office due to specific handling requirements

Who is AstraZeneca?

- AstraZeneca is a company that makes prescription medicines
- AstraZeneca has offered prescription savings programs to people who qualify since 1978

The Program can be changed or stopped by AstraZeneca at any time or for any reason.

Do you qualify for the Program?

You may qualify for the Program if:

✓ You are a US resident

✓ You meet certain household income limits
(visit **www.azandmeapp.com** or call **1-800-292-6363** or **1-800-AZandMe** for details)

✓ **And one** of the following applies:

- ☐ You do not have prescription drug coverage that helps pay for your AstraZeneca medicines
- ☐ You participate in Medicare Part B or Part D
- ☐ You participate in Medicare Part B, Medicare Part D or Medicare Advantage

Please review the checklist on the next page to ensure that your application is complete and ready for submission.

AZ&ME™
AstraZeneca Prescription Savings Program

AZ&Me Prescription Savings Program Application Checklist

The following items must be submitted by mail or by fax to complete your application. Keep this page for your records.

Send ALL the following TOGETHER:

- ☐ A completed application, signed and dated by you and your prescriber
  Blank applications can be found on www.azandmeapp.com. This application is for our Specialty Care medicines (Oncology & Respiratory/Immunology Biologics Products). Applications for other AZ products are available on www.azandmeapp.com.
- ☐ The completed prescription on page 3 of this application

Please do not send your medical records with your application.

MAIL your completed application, prescription, and required proof of income documentation to:

AZ&Me Prescription Savings Program
PO Box 222178
Charlotte, NC 28222

Or

Your doctor's office may FAX your completed application, prescription and required documentation, with a fax cover sheet.

For all Specialty Care brands (Oncology & Respiratory/Immunology Biologics Products): 1-877-239-0867.

Applications and prescriptions not faxed from the doctor's office will be deemed invalid.

Important Information about your Application

Information provided to us will be used to determine possible eligibility for help from another program such as Medicaid. You may be required to submit documentation supporting that you do not qualify for other prescription assistance.

For Prescription Refills, call 1-800-292-6363

Once you are enrolled in the Program, your prescriptions can easily be refilled by calling our phone line Monday through Friday, 9:00 AM – 6:00 PM ET.

Reset Form

Application for Free AstraZeneca Medicines

Specialty Care Products (Oncology & Respiratory/Immunology Biologics Products) Page 3 of 5

AZ&ME™
AstraZeneca Prescription Savings Program

PATIENT INFORMATION:

*Please print clearly in **blue or black** ink. Asterisks indicate required fields.*

☐ New Application ☐ Re-enrollment

Patient Name*: _____
First *Middle Initial* *Last*

Date of Birth*: _____/_____/_____
(MM/DD/YYYY)

If covered by Medicare include your Medicare MBI number found on your Medicare card*: _____

Address*:_____ City*:_____ State*: _____ Zip*:_____

☐ Patient has no current address. (Medication will be shipped to HCP's office) PLEASE NOTE: Medications cannot be shipped to Post Office (PO) boxes.

Please check box for preferred phone number to contact you: ☐ Phone*: (_____) _____ ☐ Mobile Phone: (_____)_____

E-mail: _____

Primary language spoken: ☐ English ☐ Spanish ☐ Other:_____

PRESCRIBER INFORMATION: This form will replace all previous prescriptions that may have been sent.

This section MUST be completed by Prescribing Physician

Prescriber Name*: _____ Phone*: (_____) _____ Fax*: (_____) _____

Address*:_____ City*:_____ State*:_____ Zip*:_____

Prescriber E-mail:_____ NPI*: _____ State License Number (SLN):_____

Office Contact Name*:_____ Phone*: (_____)_____ Practice Name*: _____

☐ Syringe ☐ Pen ☐ Vial ☐ Oral ☐ Other

Medication*:	Strength*:	Dosage*:	Frequency/Directions* (for weight-based medications please include exact dose or patient weight)	Quantity*:	Refills*:	Form* - Syringe - Pen - Vial - Oral - Inhaler

SHIP MEDICATION TO: ☐ **PATIENT** ☐ **PRESCRIBER†**

(†For Prescribers in Ohio ONLY: Pursuant to OAC 4729-5-10, Ohio prescribers must be approved by the Ohio Board of Pharmacy to be a pick-up station)

Prescriber Signature:** (must be wet signature)* _____ ***Date:_____

NY Prescribers must attach a separate prescription in accordance with NY pharmacy law.

Questions? Call **1-800-292-6363** Monday–Friday, 9:00 AM to 6:00 PM ET or visit **www.azandmeapp.com**
Specialty Care brands (Oncology & Respiratory/Immunology Biologics Products) Fax: 1-877-239-0867

Application for Free AstraZeneca Medicines

Specialty Care Products (Oncology & Respiratory/Immunology Biologics Products) Page 4 of 5

AZ&ME™
AstraZeneca Prescription Savings Program

Program Eligibility Information: *Please print clearly in **blue or black** ink.*

INCOME:

$_____ Monthly OR $_____ Yearly

Income Verification: AZ&Me and its authorized third-party agents will use my date of birth and/or additional demographic information as needed to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact my credit score. AZ&Me and its authorized third-party agents reserve the right to ask for additional documents and information at any time.

What is the total combined household income before taxes? *(Include yourself, all adults, and all dependents)*

Number of people in your household: _____ Number of dependents in your household under 18 years of age:_____

(Include yourself, all adults, and all dependents)

INSURANCE:

Do you have any form of prescription drug coverage? ☐ Yes ☐ No

If Yes, please check all that apply:

☐ Employer-furnished or commercial/private drug coverage. Please provide plan name and ID number:_____

☐ VA or Military Benefits ☐ Other Prescription Coverage _____

☐ Medicaid Prescription Drug Coverage

☐ Medicare Part B (medical benefit that covers some prescription medications)

☐ Medicare Part D (prescription drug coverage). Please provide payer name:_____

☐ Medicare Part D Member ID: _____ ☐ Medicare Low Income Subsidy (LIS)

Do you have Medicare supplemental (Medigap) coverage? ☐ Yes ☐ No

If so, does your supplemental coverage cover your total out-of-pocket cost for your medication? ☐ Yes ☐ No

CONSENT:

I GIVE my doctor, AstraZeneca, and the Program administrator and their employees, agents, and contractors permission to verify my information to make sure it is true and complete; contact me by mail, email, texting, or phone about the Program and about other products, programs, or services that might interest me or for which I may be eligible; contact me in order to ensure that I have received the medicines sent by the Program.

I PROMISE that all the information I provide to AstraZeneca is true and complete; I am authorized to sign any and all applications and forms related to this Program; I do not have any assistance or insurance that would help pay for my medicines (other than Medicare, if applicable); I will contact the Program if any of my information about my prescription drug coverage or insurance changes.

I UNDERSTAND that the Program will only use my information to decide if I qualify to participate in the Program; administer or improve the Program; communicate with insurance plans, including Medicare plans; share my information with the Centers for Medicare and Medicaid Services; share my information with a new patient assistance program administrator if the product I am prescribed is transferred to another manufacturer.

CONSENT:

I UNDERSTAND that AZ&Me and its authorized third-party agents will use my date of birth and/or additional demographic information as needed to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process. As a soft credit inquiry, this option will not impact my credit score. AZ&Me and its authorized third-party agents reserve the right to ask for additional documents and information at any time.

I UNDERSTAND that I may be required to apply for prescription assistance through a government assistance program to maintain eligibility in the Program.

I UNDERSTAND that I can call 1-800-292-6363 at any time to withdraw from the Program and/or cancel my permission to use my information. I can visit www.globalprivacy.astrazeneca.com to review AstraZeneca's Privacy Notice.

I UNDERSTAND that the Program can request more information from me at any time; AstraZeneca can change or stop the Program at any time or for any reason.

I UNDERSTAND that once my information has been disclosed to my doctor, federal privacy laws may no longer restrict its use or disclosure, but the Program will only use my information as described in this form.

I MAY refuse to sign this authorization form and if I refuse, my eligibility for health plan benefits and treatment by my healthcare provider will not change, but I will not have access to the Program.

I GIVE the Program, and the Program administrators, permission to contact the person named below with follow-up questions (this only applies if someone completed this application for you).

This authorization form will be effective for 2 years unless it expires earlier by law or I cancel it in writing. I have a right to receive a copy of this form after I have signed it.

☐ Text me about AZ&Me Patient Assistance Program information. By checking this box, I consent to receive text messages after enrollment into AZ&Me Patient Assistance Program. For each program service, I will receive a welcome text asking me to reply CONFIRM to opt-in. Message and data rates may apply; number of messages varies based on program use but is up to 10 texts per month. Reply STOP to cancel. Privacy Notice and full Terms available at https://www.globalprivacy.astrazeneca.com/ or http://goto.az/azmetc. If this box is NOT checked, you will NOT receive text messages from the AZ&Me Patient Assistance Program

Please provide the mobile phone number you would like to receive texts _____

Signature of Applicant or Parent/Legally Authorized Representative. *If patient is a minor, parent or legally authorized representative should sign here.*

Relation to Patient: ☐ Patient ☐ Parent ☐ Legally Authorized Representative of Patient

Patient Name_____

X_____**Date:**_____/_____/_____(MM/DD/YYYY)

If someone helped you with this application and you want them to answer questions for you, please give us their name and phone number:

*Helper's Name:*_____*Helper's Phone: (* _____ *)* _____

Note: If a helper's name is not provided, they will not be able to act on the patient's behalf without a separate authorization from the patient.

AstraZeneca

Questions? Call **1-800-292-6363**
Monday–Friday, 9:00 AM to 6:00 PM ET or visit **www.azandmeapp.com**
Specialty Care brands (Oncology & Respiratory/Immunology Biologics Products) Fax: 1-877-239-0867