Application *for* Free AstraZeneca Medicines

PO Box 66551, St. Louis, MO, 63166-6551

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 allows you to get free medicines if you qualify. It is not a government program or an insurance plan.
- If you qualify, you may get free AstraZeneca medicine for up to one year, depending upon the Program in which you are enrolled. AstraZeneca will send you an application for renewal once your enrollment ends.
- Most medicines will be sent to your home. Some medicines must be sent to your doctor's office unless your doctor sends a letter to the Program indicating these medicines can be sent to your home.
- Most medicines are sent in a 90-day supply.

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 U.S. Resident, Green Card or Work Visa holder.

✓ You meet certain income limits:

No. of people in your household	Total monthly income	Total yearly income
1 person	less than $2,500 a month	less than $30,000 a year
2 people	less than $3,333 a month	less than $40,000 a year
3 people	less than $4,166 a month	less than $50,000 a year
4 people	less than $5,000 a month	less than $60,000 a year
5 people	less than $5,833 a month	less than $70,000 a year

Income limits may be higher in Alaska and Hawaii.

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

☐ You don't have prescription drug coverage that helps pay for your AstraZeneca medicines.	☐ You participate in Medicare Part D and have already spent at least 3% of your annual household income out-of-pocket this year on prescription medicines.	☐ You have recently faced a financial challenge: *(check the appropriate box below and provide supporting documents with your application)* ☐ Change in household income (letter from employer) • Loss of employment (letter from former employer or unemployment office) • Loss of, or change in, prescription drug insurance ☐ Change in marital status (legal record supporting change) ☐ Change in household number (copy of birth or death certificate)

If you think you qualify for the Program:

Complete this application (or) visit **www.azandme.com** to fill out our online application.

AZ&me AstraZeneca Prescription Savings Programs

*Please print clearly in **black** or **blue ink**.*

Personal Information

Name ____ Date of Birth ___/___/_______ (mm/dd/yyyy)
First Middle Initial Last

Address ______________________________ City _________________ State ______ Zip ________

Phone (_______)________________________________

Marital status:
- ☐ Married ☐ Divorced
- ☐ Single ☐ Widow/Widower

U.S. Veteran:
- ☐ Yes ☐ No

Disabled: (approved by Social Security)
- ☐ Yes ☐ No

Sex:
- ☐ Male ☐ Female

Primary language spoken: (optional)
- ☐ English
- ☐ Spanish
- ☐ Other__________________

Please provide your **Social Security Number** if you have one.
This information will only be used to determine if you are eligible and once qualified as described below.

___ ___ ___ – ___ ___ – ___ ___ ___ ___

If you don't have a Social Security Number you must provide **one** of the following:

- ☐ Green Card Number ____
- ☐ A copy of the confirmation letter from the government stating that you have applied for a US Green Card
- ☐ Work Visa Number ____

Income

Number of people in your household __________
(Include yourself, your spouse and your dependents)

What is your total combined household income? $__________Monthly **or** $__________Yearly
(Include yourself, your spouse and your dependents)

***NOTE:** You will need to provide proof of income (see page 4 for details).*

Insurance

Do you have any form of prescription **drug** coverage?

- ☐ Employer furnished or private drug coverage
- ☐ Medicaid
- ☐ Medicare Part A
- ☐ Medicare Part B
- ☐ Medicare Part D *(please complete the Medicare Part D worksheet on page 3)*
- ☐ VA or Military Benefits
- ☐ State assistance program for medicines
- ☐ **None**

MEDICARE PART D PATIENTS ONLY *To find out if you qualify, follow these steps:*

Worksheet for Medicare Part D Prescription Assistance

1. Obtain one of the following documents:
   - ☐ Explanation of Benefits Statement from your Medicare Part D plan provider
   - ☐ Pharmacy print-out of year-to-date prescription history
2. Enter the total amount your household spent on prescription drugs this year .... $_______________
3. Enter your expected gross annual income .... $_______________
4. Multiply line 3 by 3% (.03) – Example: $15,000 x .03 = $450 .... $_______________
5. Is line 2 **GREATER THAN** line 4? ☐ **Yes** ➜ *Sign on the line below* ☐ **No** ➜ *You do not qualify at this time*

By signing below, I certify that I am authorized to sign and the information provided to AZ&Me Prescription Savings Program is complete and accurate and I meet the following requirements: 1) I am enrolled in a Medicare Part D plan; 2) I meet the income requirements of this program; and 3) I have spent at least 3% of annual household income on outpatient prescription drugs this calendar year.

Medicare Part D patients ONLY sign here: X____ **Date** ____/____/________ (mm/dd/yyyy)

Consent *(ALL applicants must complete this section.)*

I give the Program, the Program administrators, and my doctor permission to:

- Check my information to make sure it is true and complete
- Share my information with the pharmacists that may supply my medicine
- Share my information with the people helping with the Program
- Contact me by mail or phone about the Program and about other products, programs, or services that might interest me
- Contact me in order to make sure that I have received the medicines sent by the Program

I promise that:

- All the information in this application, including all copies of documents proving my income, is true and complete
- I am authorized to sign this application
- I do not have any assistance or insurance that would help pay for my medicines (other than Medicare Part D, 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 Part D plans
- Share my information with the Centers for Medicare and Medicaid Services

I understand that I can call 1-800-424-3727 at any time to:

- Withdraw from the Program
- Cancel my permission to use my information and withdraw from the Program
- Get a copy of the AstraZeneca Privacy Statement

I understand that:

- The Program can ask for more information from me at any time
- AstraZeneca can change or stop the Program at any time or for any reason

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

Signature of Applicant or Legal Guardian

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:* (______)____________________

Questions? Call 1-800-424-3727 or visit www.azandme.com

AZ&me AstraZeneca™ Prescription Savings Programs

Doctor's Information

Doctor's Name ______________________ Phone (_____)______________

State License # ______________________ Fax (_____)______________

Address ______________________

City ______________________ State ________ Zip ____________

➜ ***Please be sure to include prescription with application.***

Medicines

List any medicines you are **taking**:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Attach a separate piece of paper if you need more space.

List any medicines you are **allergic** to:

____

____

Next Step

Send the following:

✓ Your completed application

✓ Your prescription

✓ Proof of income: *(include **one** of the following)*

- ☐ A copy of last year's federal income tax returns for yourself, spouse, and dependents
- ☐ All income statements from jobs (W2 or 1099)
- ☐ Social Security Income Yearly Benefits Statement

If you have Medicare Part D:

✓ Total amount of household income spent on prescription drugs this year: *(include **one** of the following)*

- ☐ Explanation of Benefits Statement from your Medicare Part D plan provider
- ☐ Pharmacy print out of year-to-date prescription history

If you have experienced financial hardship:

✓ Supporting documentation explaining change in circumstance and new income

MAIL completed application to:

AZ&Me Prescription Savings Program
PO Box 66551
St. Louis, MO 63166-6551

or

FAX completed application to:

800-961-8323

NOTE: *If you fax the application, the prescription must be sent from your doctor's office.*

Questions? Call 1-800-424-3727 or visit www.azandme.com

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