

Application *for* Free AstraZeneca Medicines

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



Prescription Savings Programs

What is the AZ&Me Prescription Savings Program?

- The AZ&Me Prescription Savings program (the Program) is a program 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 you are enrolled in. AstraZeneca will send you an application for renewal once your enrollment terms.
- Most medicines will be sent to your home. However, certain medicines must be sent to your doctor's office unless a letter is sent to the Program by your doctor indicating that 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.

Income limits in order to qualify

Income limits may be higher in Alaska and Hawaii.

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

Do you qualify for the Program?

You may qualify for the Program if:

- You don't have other insurance that helps pay for your AstraZeneca medicines **OR** you participate in Medicare Part D.
- You are a US Resident, Green Card or Work Visa holder.
- You meet the income limits in the table below.
- You have Medicare Part D and have already spent at least 3% of your annual household income out-of-pocket this year on prescription medicines.

How do you get started?

- Fill out this application **OR** complete the application online by visiting www.azandme.com.
- If you have trouble filling out this application, call 1-800-424-3727
- Mail the completed application to:

AZ&Me Prescription Savings Program
PO Box 66551
St. Louis, MO, 63166-6551
OR
Fax: 1-800-961-8323

From Your Doctor *Please print clearly in black or blue ink.*

Doctor's Name: _____ Phone () _____

DEA or State License # (ask your doctor) _____ Fax () _____

Address _____

City _____ State _____ Zip _____

Include prescription with this application

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



Personal Information

Name _____ Date of Birth ___/___/___ (mm/dd/yyyy)

Address _____ City _____ State _____ Zip _____

Phone () _____ Male Female

Marital status:

- Married Divorced
 Single Widow/Widower

U.S. Veteran:

- Yes No

Disabled:

- Yes No

Primary language spoken (optional):

- English
 Spanish
 Other _____

Ethnic origin (optional):

- Asian
 Black
 Hispanic
 White
 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 _____

Medicines

List any medicines you are **taking**:

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

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

Income

Number of people in your household
 (yourself, your spouse, and dependents): _____

Total combined income for yourself, your spouse, and dependents:

\$ _____ Monthly **or** \$ _____ Yearly

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



Proof of Income

Do you have a copy of your federal income tax return from last year?

YES

Please send us a copy of last year's **Federal Income Tax Returns** for yourself, your spouse, and dependents

NO

If you didn't file a federal income tax return last year, you **must** send a copy of:

- All income statements from jobs (W2 or 1099)
or
 Social Security Income Yearly Benefits Statement

Insurance

Do you have any form of prescription drug coverage?

- | | |
|--|---|
| <input type="checkbox"/> Employer furnished or private drug coverage | <input type="checkbox"/> VA or Military Benefits |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> State assistance program for medicines |
| <input type="checkbox"/> Medicare Part A | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Medicare Part B | <input type="checkbox"/> None |
| <input type="checkbox"/> Medicare Part D (please complete the section below) | |

If you noted you have Medicare Part D, please complete this section.

How much has your household spent on prescription medicines since the beginning of the year?

Please provide documentation of the amount you entered above in the form of your most recent Explanation of Benefits (EOB) statement from your Medicare Part D plan provider or a pharmacy print-out of your year-to-date prescription history, which shows the amount your household has spent on prescription medication this year.

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 eligibility requirements:

- i. I am enrolled in Medicare Part D;
- ii. I have an income at or below \$30,000 as an individual or \$40,000 as a couple; and
- iii. I have spent at least 3% of annual household income on outpatient prescription drugs this calendar year

Patient Name: _____ Signature: _____
(please print)

Date: _____

Have you had a Change in Circumstance?

If you have experienced any change in circumstance, which you believe changes your eligibility, please check the appropriate box below and provide supporting documentation explaining your situation. Specific circumstances and examples of acceptable documentation include:

- Loss of employment (letter from former employer, unemployment service or physician required)
- Change in annual household income (financial documentation required, i.e., letter from employer)
- Loss of, or change in, prescription drug insurance coverage
- Change in marital status (legal document supporting change in status required)
- Change in household number (copy of birth or death certificate)

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



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 _____

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: () _____

Before you mail this application**You must:**

- Attach your prescription
- Attach a copy of last year's federal income tax returns for yourself, spouse, and dependents (or other proof of income)
- Include your doctor's license number (ask your doctor)
- Attach your most recent Explanation of Benefits (EOB) statement from your Medicare Part D plan provider or a print-out of your year to date prescription spending history from your pharmacy (if you have Medicare Part D)
- Attach supporting documentation explaining change in circumstance (if applicable)

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