Application *for* Free AstraZeneca Medicines

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

AZ&me AstraZeneca
Prescription Savings
program for people without insurance

What is the AZ&Me Prescription Savings program for people without insurance?

- The AZ&Me Prescription Savings program for people without insurance (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 will get free medicine for up to one year. At the end of that year, AstraZeneca will send you an application for renewal.
- Most medicines will be sent to your home. Some medicines will be sent to your doctor's office.
- Most medicines are sent in a 90-day supply.

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

Who is AstraZeneca?

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

Do you qualify for the Program?

You probably qualify for the Program if:

- You don't have other insurance that helps pay for your medicines.
- You meet the income limits in the table below.

How do you get started?

- Fill out this application.
- If you have trouble filling out this application, call 1-800-424-3727
- Mail the completed application to:
  PO Box 66551
  St. Louis, MO, 63166-6551

Income limits in order to qualify

Current income limits are based on 2007 program guidelines and might change; 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

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
☐ Single
☐ Divorced
☐ 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.

Insurance

Do you have any form of prescription drug coverage?

- ☐ Employer furnished or private drug coverage
- ☐ VA or Military Benefits
- ☐ Medicaid
- ☐ Medicare Part B (covers some medicines)
- ☐ Medicare Part D
- ☐ State assistance program for medicines_____
- ☐ Other _____
- ☐ None

Have you applied for Medicaid in the past and been denied?

☐ Yes ☐ No *If yes, please attach a copy of the Medicaid denial letter.*

Income

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

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

$_____ Monthly **or** $_____ Yearly

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

If you don't have any of these documents, please call 1-800-424-3727

Consent Information

I **give** AstraZeneca, 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
- 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)

Mail completed application to:

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