

TEZSPIRE® (tezepelumab-ekko) ENROLLMENT FORM



FAX COMPLETED FORM
TO: 1-888-388-6016

PLEASE COMPLETE THE FORM IN ITS ENTIRETY, UNLESS INDICATED AS OPTIONAL.

PATIENT INFORMATION WRITE NAME EXACTLY AS SHOWN ON INSURANCE CARD.

First Name:	Last Name:		
Date of Birth: / /	Gender at Birth: ☐ Male ☐ Female ☐ Not Specified		
Street Address:	City:	State:	ZIP Code:
Email Address:	Phone:	☐ Home ☐ Mobile	
Preferred Language: ☐ English ☐ Spanish			

Parent/Guardian or Legal Representative (required if patient is a minor)

Full Name:	Phone:	DOB: / /	Relationship:
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OPTIONAL – FAST START PROGRAM THIS SECTION TO BE COMPLETED BY THE PATIENT.

The TEZSPIRE Together Fast Start Program is available to newly prescribed TEZSPIRE patients who have **commercial or private insurance**, including state and federal plans commonly referred to as “healthcare exchange plans.” This program helps eligible patients obtain TEZSPIRE while coverage is being secured, up to program limits.

☐ By checking this box, I agree that I have read, understand, and accept the Fast Start Program Terms & Conditions on page 6 and want to enroll in the Fast Start Program.

Must also select “I consent” and sign below to participate in the Fast Start Program.

OPTIONAL – CO-PAY PROGRAM



SCAN the QR code or visit [Tezspire.com](https://tezspire.com) for enrollment in the TEZSPIRE Together Co-Pay Program for commercially insured patients.

PATIENT CONSENT THIS SECTION TO BE COMPLETED BY THE PATIENT.

US STATE LAW CONSENT TO PROCESS HEALTH DATA

I. Consent to Health Data Processing for TEZSPIRE Together

Please read **Consent to Health Data Processing** for TEZSPIRE Together on page 4 and then select one of the below responses.

NOTE: Select “I consent” to proceed with enrollment. If you select “I do not consent,” you will not be able to continue enrolling in the TEZSPIRE Together Program.

- ☐ I **consent** to the collection, processing, and disclosure of my Health Data for the purposes set forth on page 5.
- ☐ I **do not consent** to the collection, processing, or disclosure of my Health Data for the purposes set forth on page 5.

PATIENT AUTHORIZATION THIS SECTION TO BE COMPLETED BY THE PATIENT.

I have read and agree to the Authorization for Use and Disclosure of Protected Health Information on pages 4–5.

NOTE: Legal representative must sign if the patient is under 18 years of age.



Signature of Patient (or legal representative)



Name of Patient (or legal representative)



Date MM/DD/YYYY

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ENROLLMENT FORM



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DEVICE SELECTION & ACQUISITION METHOD

WHICH TEZSPIRE
DEVICE DO YOU PREFER?

Select ONE

☐ Pre-filled Syringe

☐ Pre-filled Pen

HOW DO YOU PREFER
TO OBTAIN TEZSPIRE?

OR

☐ Buy & Bill
(Medical Benefit)

☐ Specialty Pharmacy
(Pharmacy & Medical Benefits)

Specialty Pharmacy (Pharmacy Benefit)

WHERE WILL TEZSPIRE
BE ADMINISTERED?

OR

☐ HCP Office

☐ Alternate Injection Site

Patient Administered

NOTE: If your selected device is not covered under the first benefit, then TEZSPIRE Together will run a benefits verification for the second benefit type. Requests requiring Specialty Pharmacy fulfillment will be sent to **ASPN Pharmacies*** for processing and follow-up.
*Amgen, the manufacturer of TEZSPIRE, has entered into a contract with ASPN Pharmacies to provide patient support services after you have prescribed TEZSPIRE.

Alternate Injection Site (required if selected above)

Site Name:

Site NPI #:

Street:

City:

State:

ZIP Code:

INSURANCE INFORMATION

WHICH TYPE OF INSURANCE DOES YOUR PATIENT HAVE?

☐ Commercial/Private Insurance ☐ Government-Provided (eg, Medicare/Medicaid/TRICARE) ☐ Uninsured

NOTE: TEZSPIRE Together will work to identify the patient's pharmacy insurance information.

	REQUIRED	OPTIONAL
	Primary Medical Insurance	Secondary Medical Insurance
Insurance Provider		
Insurance Phone		
Cardholder Name (If not the patient)		
Cardholder DOB		
Policy #		
Group #		



If your patient is uninsured or underinsured, they can call **1-888-897-7473** to see if they may qualify for assistance through the TEZSPIRE Patient Assistance Program.



Please attach copies of all insurance cards you have on file.

By completing and submitting this form, you represent that your patient has requested and authorized the disclosure of their personal health information to Amgen and AstraZeneca and their agents for Amgen and AstraZeneca to provide the patient support services described in this paragraph. You represent that you have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Amgen and AstraZeneca and their agents will use the patient's name, date of birth, contact information, prescriptions, and other necessary health information listed in this form for reimbursement services related to this prescription, including to verify their insurance benefits, and to contact the patient directly for the administration of these patient support services; 2) Amgen and AstraZeneca will then disclose the patient's personal information to the insurer(s) listed on this form for the same purposes; 3) the patient can withdraw their consent by contacting Amgen and AstraZeneca at 1 (888) 897-7473 or visiting <http://www.amgen.com/DataSubjectRights>, but if the patient does not agree to, or withdraws consent for, these uses and disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Amgen and AstraZeneca to process the patient's personal information; and 4) the patient can view more details about Amgen and AstraZeneca's privacy notice at <https://privacy-amgenandaz.astrazeneca.com>.

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DIAGNOSIS CODES (ICD-10-CM CODE)



DO NOT ATTACH CLINICAL NOTES

Severe Uncontrolled Asthma (SUA)

- ☐ **J45.50** Severe persistent asthma, uncomplicated
- ☐ **J45.51** Severe persistent asthma, with (acute) exacerbation
- ☐ **J45.5** Severe persistent asthma

Indicate known drug allergies

- ☐ Known drug allergies: _____
- ☐ No known drug allergies

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

- ☐ **J33.0** Polyp of nasal cavity
- ☐ **J33.1** Polypoid sinus degeneration
- ☐ **J33.8** Other polyp of sinus
- ☐ **J33.9** Nasal polyp, unspecified

- ☐ Other ICD-10-CM Code: _____
- ☐ Concomitant medications: _____

NOTE: Clinical notes and additional documents are NOT required for us to provide the services requested. Sending clinical documentation to TEZSPIRE Together could delay our response time back to your office. Please DO NOT provide anything beyond the information requested on this Enrollment Form.

PRESCRIPTION INFORMATION REQUIRED FOR SPECIALTY PHARMACY FULFILLMENT.

PATIENT INFORMATION ALL PATIENT INFORMATION FIELDS ARE REQUIRED.

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

TEZSPIRE (tezepelumab-ekko) PRESCRIPTION

Complete this Rx to send the prescription to a Specialty Pharmacy.

TEZSPIRE (tezepelumab-ekko) 210 mg/1.91 mL (110 mg/mL)

☐ **Pre-filled Syringe**
(NDC: 55513-0112-01)

OR

☐ **Pre-filled Pen**
(NDC: 55513-0123-01)

SIG: Inject 210 mg (1 pre-filled syringe)
SC every 4 weeks

SIG: Inject 210 mg (1 pre-filled pen)
SC every 4 weeks

Refills: _____

Quantity: 1

Preferred Specialty
Pharmacy (Optional): _____

OPTIONAL - FAST START PRESCRIPTION

Complete this section if your commercially eligible patient is enrolling in the Fast Start Program. See page 1 for program details.

TEZSPIRE (tezepelumab-ekko) 210 mg/1.91 mL (110 mg/mL)

☐ **Pre-filled Syringe**
(NDC: 55513-0112-01)

OR

☐ **Pre-filled Pen**
(NDC: 55513-0123-01)

SIG: Inject 210 mg (1 pre-filled syringe)
SC every 4 weeks

SIG: Inject 210 mg (1 pre-filled pen)
SC every 4 weeks

Refills: 11

Quantity: 1

PRESCRIBER INFORMATION PLEASE COMPLETE ALL REQUIRED FIELDS MARKED WITH AN ASTERISK (*).

Prescriber Full Name:* _____ Office Contact Name: _____

Tax ID #:* _____ Practice/Clinic Name:* _____

Prescriber NPI #:* _____ Prescriber State License #: _____

Site/Group NPI #:* _____ Street:* _____

Medicare Provider # (PTAN): _____ City:* _____ State:* _____ ZIP Code:* _____

Medicaid Provider #: _____ Phone:* _____ Ext: _____ Fax:* _____

I authorize Amgen, Inc., its affiliates, agents, and contractors (collectively "Amgen") to transmit the above prescription by any means allowed under applicable law to the preferred Specialty Pharmacy (identified above) for my patient unless the patient's payer mandates a different Specialty Pharmacy for my patient.

Prescriber Attestation: If TEZSPIRE is shipped to my office, I will accept TEZSPIRE on behalf of my patient for administration in the office. I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. I understand that noncompliance with state-specific requirements could result in outreach to me.

By signing below, I certify as a licensed healthcare professional that the patient named on this form has, or has had, a diagnosis for an FDA-approved indication for TEZSPIRE. I also certify that this is my legal signature.

CA, MA, NC, & PR: Interchange is mandated unless the prescriber writes the words "No Substitution": _____

NY & IA providers: Please submit electronic prescription.



Prescriber Signature (Dispense as written)



Date MM/DD/YYYY



Prescriber Signature (Substitution permitted)



Date MM/DD/YYYY

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please read the following carefully, then date and sign where indicated on page 1.

I. Uses and Disclosure of Protected Health Information

I authorize Amgen, AstraZeneca Pharmaceuticals LP, and their data processors (collectively, "Amgen and AstraZeneca") to collect, use, and disclose my protected health information for the following purposes:

- To operate, administer, enroll me in, and/or continue my participation in Amgen and AstraZeneca's TEZSPIRE Together program or any other Amgen- and AstraZeneca-affiliated patient support services and activities related to my condition or treatment (for example, co-pay card programs, reimbursement assistance programs, drug coverage verification, nurse educator services, adherence program and disease management support);
- To contact, with my permission, my doctor and the rest of my health care team and share with them my health information that may be useful for my care;
- To improve, develop, and evaluate Amgen and AstraZeneca's products, services, materials and programs related to my condition or treatment.

In order for Amgen and AstraZeneca to provide me with the services and/or programs described above, Amgen and AstraZeneca need to collect and use my personal information, including my protected health information. I understand that my protected health information may include any information, in electronic or physical form, in the possession of or derived from a health care provider, health care plan, pharmacy, pharmaceutical company, laboratory and/or their contractor (each, a "Health Care Provider"). This may include select information from or about my medical history and general health, my health care plan benefits, payment limits or restrictions covered by my health care plan policy, and/or my adherence to my treatment.

I authorize my Health Care Providers to disclose my protected health information to Amgen and AstraZeneca, and between themselves, as necessary, but only for the purposes stated above in this Authorization. I understand that certain of my Health Care Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen and AstraZeneca in exchange for disclosing my protected health information and/or for using my information to contact me with communications about Amgen and AstraZeneca products which have been prescribed to me (for example, medication reminder programs and other patient support services).

II. Expiration, Right to Obtain a Copy, and Right to Cancel

I understand that by signing this form, I authorize my Health Care Providers or others who might hold my health information to disclose it to Amgen and AstraZeneca. I also understand I am authorizing my personal information, including my protected health information, to be used for the purposes described above. I understand and agree that by signing below, I am authorizing those who rely on this Authorization to disclose my protected health information for the earlier of five (5) years or until my participation in Amgen and AstraZeneca's TEZSPIRE Together ends through my cancellation, unless a shorter time period is required by state law.

I understand that I can obtain a copy of this Authorization or cancel this Authorization at any time by calling 1-888-TZSPIRE (1-888-897-7473). If I cancel this Authorization, I will no longer qualify for the services described. I also understand that if a Health Care Provider is disclosing my protected health information to Amgen and AstraZeneca in reliance on this Authorization on an on-going basis, my cancellation with Amgen and AstraZeneca will be effective with respect to any such Health Care Providers as soon as they receive notice of my cancellation.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION *(Continued)***III. No Effect on Treatment**

I understand I do not have to sign this Authorization and that my enrollment in any of the services and/or programs described above is entirely voluntary.

I understand that Amgen and AstraZeneca, as well as Health Care Providers, cannot require me, as a condition of having access to medications, prescription drugs, treatment or other care, to sign this Authorization. Federal Law (including HIPAA) requires a signed authorization in order for Amgen and AstraZeneca to collect my protected health information from my Health Care Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Health Care Providers.

IV. Information Received from Health Care Providers

I understand that once my protected health information has been disclosed to Amgen and AstraZeneca, federal privacy laws may no longer apply and may no longer protect it from further disclosure, and that Amgen and AstraZeneca may disclose my protected health information to their data processors, contractors, and business partners for their business purposes. Amgen and AstraZeneca agree, however, to protect my protected health information by only using and disclosing it as stated in the Authorization or as otherwise allowed or required by law.

US STATE LAW CONSENT TO PROCESS HEALTH DATA**I. Consent to Health Data Processing for TEZSPIRE Together**

I consent to Amgen and AstraZeneca processing my Health Data for the following purposes:

- To enroll me and manage my participation in Amgen and AstraZeneca's TEZSPIRE Together program, which includes activities related to my condition or treatment (for example, co-pay card programs, payer medication coverage verification, nurse educator support, disease management support), and to manage Amgen and AstraZeneca's products, services, and programs related to my condition or treatment.

Amgen and AstraZeneca use the following when they administer the TEZSPIRE Together program:

- Health Data – my name (and the name of my caregiver if applicable), gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that my consent to processing is required for me to participate in the TEZSPIRE Together program. I also understand that Amgen and AstraZeneca will not sell my Health Data to third parties, but Amgen and AstraZeneca may disclose my Health Data to Amgen and AstraZeneca's data processors, contractors, and business partners for Amgen and AstraZeneca's business purposes related to the TEZSPIRE Together program. I understand that Amgen and AstraZeneca may use my Health Data to contact me by mail, email, or telephone for the above purposes. I also understand that if I do not consent to the use of my Health Data for the above purposes, I will not be able to participate in the TEZSPIRE Together program. Finally, I understand that I may withdraw my consent to processing my Health Data for the above purposes at any time using one of the methods listed in the Additional Disclosures section below and that if I withdraw my consent, I will no longer be able to participate in the TEZSPIRE Together program.

II. Additional Disclosures

I understand that participation in the TEZSPIRE Together program and, if I have consented, receipt of marketing communications are optional services at no cost to me. The consent(s) above in no way affects my right to obtain any medications and I do not have to provide consent to be able to receive any medications. To obtain a copy of the consent(s) above or to withdraw my consent to collection, processing, and/or disclosure of my Health Data for any of the above purposes to which I have consented, I can contact Amgen and AstraZeneca by visiting www.amgen.com/DataSubjectRights or calling 1 (888) 897-7473. For more information about Amgen and AstraZeneca's privacy practices, their Privacy Statement can be found at <https://privacy-amgenandaz.astrazeneca.com/>.

TEZSPIRE® FAST START PROGRAM TERMS & CONDITIONS

The **TEZSPIRE®** Fast Start Program is available to newly prescribed TEZSPIRE patients who have commercial or private insurance, including state and federal plans commonly referred to as “healthcare exchange plans.” This program helps eligible patients obtain TEZSPIRE while coverage is being secured, up to program limits.

This offer is not valid if patient is uninsured or receiving prescription reimbursement under any federal, state, or government-funded healthcare program, such as Medicare, Medicare Advantage, Medicare Part D, the Retiree Drug Subsidy Program, Medicaid, Medigap, Veterans Affairs (VA), the Department of Defense (DoD), or TRICARE or where prohibited by law. It is not valid for cash-paying or uninsured patients. Cash Discount Cards and other noninsurance plans are not valid as primary under this offer. If at any time patient begins receiving coverage under any such federal, state, or government-funded healthcare program, patient will no longer be able to use this offer and patient must call 1-888-TEZSPIRE (1-888-897-7473) to stop participation. By participating in this offer, patient acknowledges intent to pursue insurance approval for TEZSPIRE with their healthcare provider. Once insurance approval is obtained, patient is no longer eligible for this offer. No purchase necessary. **This is not health insurance.** Participation is not a guarantee of insurance coverage. Offer is not renewable. This offer is only valid in the United States, Puerto Rico, and the US territories. Other restrictions may apply. This offer is subject to change or discontinuation without notice.

- **If the patient’s insurance plan does not cover TEZSPIRE or requires a prior authorization**, the patient can receive TEZSPIRE at no cost for up to twelve (12) doses of either the pre-filled syringe (PFS) formulation or the pre-filled pen (PFP) formulation within twenty-four (24) months from the date the first dose is shipped under the Fast Start Program.
- Ongoing eligibility after the first 30 days requires that the prior authorization (PA) is submitted by the provider. If the PA is not submitted within 30 days of the first shipment, then patient will no longer be eligible for the Fast Start Program.
- If the PA results in a denial, the provider must submit the appeal within 30 days of the denial. If the appeal is not submitted within 30 days of the denial, then patient will no longer be eligible for the Fast Start Program.
- If the patient’s insurance plan releases a written policy for TEZSPIRE after a PA or appeal was previously submitted, a new PA must be submitted within 30 days of notification of policy change to remain eligible for the program.
- Existing TEZSPIRE patients whose commercial insurance is covering TEZSPIRE are not eligible to enroll into the Fast Start Program for any TEZSPIRE formulation.

Please see accompanying full [Prescribing Information](#), including [Patient Information](#) and [Instructions for Use](#).

You are encouraged to report negative side effects of AstraZeneca prescription drugs by calling 1-800-236-9933.

If you prefer to report these to the FDA, call 1-800-FDA-1088.

END OF FORM