Fill in this form **ONLINE** at TEZSPIRETogetherHCP.com, or **COMPLETE** all fields below, then **FAX** to **1-888-388-6016**.

ENROLLMENT FORM

Complete† sections indicated for each service you wish to request:
Benefits Verification‡ (Complete Sections 1, 2 & 3)
Prescription Information (Complete Sections 1 & 3)
Co-Pay Enrollment (Complete Sections 1, 3, 4 & 6)
Fast Start Enrollment (Complete Sections 1, 3, 5 & 6)
Patient Assistance Program Pre-Screening (Free Drug) (Complete Sections 1, 3 & 7)
†Sections 4, 5, 6 & 7 to be completed and signed by the patient or the patient's legal representative

TEZSPIRE® together

1. PATIENT INFORMATION

An asterisk (*) indicates required field. 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 Form of Communication: ☐ Text ☐ Email Preferred language: ☐ English ☐ Spanish

Alternative Caregiver Contact Information (the following information is required if designating):

Full Name: Phone: Email:

☐ By checking this box, I agree that it is acceptable to leave a message with this alternate caregiver/contact.

If you are approved for the TEZSPIRE **pre-filled pen for self-administration**, your TEZSPIRE prescription will be shipped to you.
Please provide your shipping address if different than the above address:

Street Address:* City:* State:* ZIP Code:*

INSURANCE INFORMATION: ☐ Commercial/Private Insurance ☐ Government-provided (eg, Medicare/Medicaid/TRICARE) ☐ Uninsured

Please complete both primary medical insurance and pharmacy insurance information and **provide front and back copies** of all medical and prescription insurance cards you have on file.

If your patient is uninsured, please make sure they complete the Patient Assistance Program Pre-Screening section on pages 4-6, or ask them to call 1-888-897-7473 to determine if they may qualify for assistance through the TEZSPIRE Patient Assistance Program.

	Primary Medical Insurance	Secondary Medical Insurance	Primary Rx Insurance	
Insurance Provider*				
Insurance Phone*				
Cardholder Name (If not the patient)*				
Cardholder DOB*				
Policy #*				
Group #*				
RxBIN/RxPCN	X	X	RxBIN:	RxPCN:

CLINICAL INFORMATION ICD-10-CM Code:* Do not attach clinical notes

☐ J45.50 Severe persistent asthma, uncomplicated
☐ J45.51 Severe persistent asthma, with (acute) exacerbation
☐ J45.5 Severe persistent asthma
☐ J45.90 Unspecified asthma
☐ J45.901 Unspecified asthma with (acute) exacerbation
☐ J45.9 Other and unspecified asthma
☐ J82.83 Eosinophilic asthma
☐ Other/Miscellaneous: _____

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

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.

‡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.

Fill in this form **ONLINE** at TEZSPIRETogetherHCP.com, or **COMPLETE** all fields below, then **FAX** to **1-888-388-6016**.

PATIENT INFORMATION

Name:* **Date of Birth:*** / /

Preferred Network Specialty Pharmacy:

TEZSPIRE® together

2. PRODUCT SELECTION & ACQUISITION METHOD

If you select a preference, a benefit verification for the 2nd preference will only be run if the 1st preference formulation is not covered.

Preference	Product Formulation	Administration Site	Acquisition Method
☐ 1st ☐ 2nd	☐ Pre-filled Pen	Patient Administered	Specialty Pharmacy
☐ 1st ☐ 2nd	☐ Pre-filled Syringe	☐ HCP Office ☐ Hospital/Infusion Center	☐ Buy & Bill ☐ Specialty Pharmacy
☐ Complete BV for both formulations		select sites from above	select methods from above

3. PRESCRIPTION INFORMATION

An asterisk (*) indicates required field. If the prescription section below is completed and signed, TEZSPIRE Together will send the prescription to the payer's mandated Specialty Pharmacy (SP). If there is not a mandated SP, please identify a specialty pharmacy from the list of network SPs where you would like the Rx to be transferred.

PRESCRIBER INFORMATION

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:*

PRESCRIPTION INFORMATION

(Select both administration options below for the prescription and Fast Start if you requested a BV preference for both administration options)

TEZSPIRE PRESCRIPTION

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

DEVICE TYPE: ☐ **Pre-filled Pen (PFP)** ☐ **Pre-filled Syringe (PFS)**

SIG: Inject 210 mg SC once every 4 weeks — Quantity Dispensed:

HCP Administration PFS (NDC: 55513-0112-01)	**1**	**Refills:***
Self-Administration PFP (NDC: 55513-0123-01)	**1**	**Refills:***

FAST START (enrollment required - see page 3)

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

DEVICE TYPE: ☐ **Pre-filled Pen (PFP)** ☐ **Pre-filled Syringe (PFS)**

SIG: Inject 210 mg SC once every 4 weeks — Quantity Dispensed:

HCP Administration PFS (NDC: 55513-0112-01)	**1**	**Refills: 11**
Self-Administration PFP (NDC: 55513-0123-01)	**1**	**Refills: 11**

REQUIRED if shipping address is different from address provided for prescriber above:

Site Name: | Site NPI:*

Street:* | City:* | State:* | ZIP Code:*

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 the prescriber's office, the prescriber accepts TEZSPIRE on behalf of the patient for administration in the office. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing. state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.

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

PATIENT INFORMATION

Name:* _____ **Date of Birth:*** / /

TEZSPIRE® together

4. CO-PAY ENROLLMENT

THIS SECTION TO BE COMPLETED BY THE PATIENT *(Insurance information from page 1 must be provided).*

Are you eligible for Medicare but receive prescription drug coverage from a former employer, union, or welfare plan?

☐ Yes ☐ No ☐ I don't know

What type of insurance do you use to pay for your TEZSPIRE prescription and, if applicable, administration at the doctor's office?

☐ Commercial or private insurance
☐ Government-provided (eg, Medicare, Medicaid, TRICARE)
☐ No insurance
☐ Unknown

The TEZSPIRE Together Co-Pay Program is open to patients with commercial or private insurance that covers TEZSPIRE, regardless of financial need. The program is not valid for patients whose TEZSPIRE prescription and/or in-office administration costs are paid for in whole or in part by a government payer (eg, Medicare, Medicaid, TRICARE).

To check eligibility for the Co-Pay Program, you must have commercial insurance, read and agree to the Co-Pay Program Terms & Conditions, provide your consent to Health Data Processing below, and provide your Authorization by signing at the bottom of this page.

☐ **By checking this box, I agree that I have read, understand, and accept the Co-Pay Program Terms & Conditions on pages 10-12 and want to enroll in the Co-Pay Program.**

NOTE: Patients under the age of 18 must have their legal representative call the TEZSPIRE Together Co-Pay Program at 1-800-818-1770 to enroll the patient over the phone.

5. FAST START PROGRAM

THIS SECTION TO BE COMPLETED BY THE PATIENT.

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.

To check eligibility for the Fast Start Program, you must have commercial insurance, read and agree to the Fast Start Program Terms & Conditions, provide your consent to Health Data Processing below, and provide your Authorization by signing at the bottom of this page.

☐ By checking this box, I agree that I have read, understand, and accept the Fast Start Program Terms & Conditions on page 9 and want to enroll in the Fast Start Program.

6. PATIENT CONSENT AND AUTHORIZATION

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 8 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 Fast Start or Co-pay Card Programs.

☐ **I consent** to the collection, processing, and disclosure of my Health Data for the purposes set forth on page 9.
☐ **I do not consent** to the collection, processing, or disclosure of my Health Data for the purposes set forth on page 9.

II. Consent to Health Data Collection & Processing for Marketing Purposes (Optional)
Please read **Consent to Health Data Collection & Processing for Marketing Purposes** on page 8 and then select one of the below responses.

☐ **I consent** to the collection and processing of my Health Data for the marketing purposes set forth on pages 8-9.
☐ **I do not consent** to the collection and processing of my Health Data for the marketing purposes set forth on pages 8-9.

III. Consent to Health Data Disclosure for Marketing Purposes (Optional)
Please read **Consent to Health Data Disclosure for Marketing Purposes** on page 9 and then select one of the below responses.

☐ **I consent** to the disclosure of my Health Data for the marketing purposes set forth on pages 7-8.
☐ **I do not consent** to the disclosure of my Health Data for the marketing purposes set forth on pages 7-8.

PATIENT AUTHORIZATION

I have read and agree to the Authorization for Use and Disclosure of Protected Health Information on pages 7-8 and understand that **I must sign below to participate in the TEZSPIRE Together Fast Start and/or Co-pay Card Program**.

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

PATIENT INFORMATION

Name:* _____ **Date of Birth:*** ___/___/___

AMGEN SAFETY NET FOUNDATION

OPTIONAL – *Non-commercially insured patients only*

7. PATIENT ASSISTANCE PROGRAM PRE-SCREENING

THIS SECTION TO BE COMPLETED BY THE PATIENT.

To check if you might qualify for the Patient Assistance Program, fill out Section 7 in its entirety (continues on page 5). No additional application is required after this form is submitted.

Residency: I have lived in the US or its territories (American Samoa, Guam, Puerto Rico, or US Virgin Islands)

☐ 6+ months ☐ Under 6 months

Patient Household Income: ☐ Monthly ☐ Annually $ _____

Gross income includes all individuals in the household. This includes wages, Social Security, Social Security disability, unemployment, pensions, and any other income. You may be asked to provide proof of income.

How many people live in your household including yourself? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other

Household size includes all individuals reported on your US tax return. If you did not file a tax return, please include all individuals who live with you.

TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL.

Indicate shipping preference if your patient is approved via ASNF. If shipping address is different from the prescriber's office, fill out shipping information in Section 3.

Single dose Pre-filled Syringe is shipped to the physician's office only, as replacement product. For single dose Pre-filled Pen, check preference below.

Single-dose Pre-filled Pen Preferred Shipment Location: ☐ Direct to patient ☐ Direct to office

Amgen Safety Net Foundation (the "Foundation") is a nonprofit patient assistance program that helps qualifying patients access Amgen medicines at no cost.

Patient Certification

I certify that:

- The information I provided on this form is complete and accurate.
- I will not request reimbursement from any insurance carrier or government health benefit program for Amgen/AstraZeneca medications that I receive from the Foundation.
- I will notify the Foundation within thirty (30) days if my financial status or health insurance coverage changes.
- If I decide to enroll in a Medicare Part D plan, I will inform the Foundation at the number below prior to enrolling. If I receive notice that I have "auto-enrolled" in a Medicare Part D plan, I will immediately inform the Foundation.
- I will not sell, trade, or distribute Amgen/AstraZeneca medications given to me by the Foundation. I understand that completing the Foundation application form is not a guarantee of eligibility for the Foundation. I understand that the Foundation reserves the right to change or terminate this program at any time without notice, or to refuse to distribute Amgen/AstraZeneca medications under this program to any patient or facility, except that if I am enrolled in a Medicare Part D plan, my benefits will continue until the end of the calendar year. I understand that if I am currently enrolled in a Medicare part D plan, I cannot utilize my Part D plan benefits for medications received through the Foundation for the duration of my enrollment in the Foundation. Any medication I receive through the Foundation will not count toward my true-out-of-pocket (TrOOP) expenses in Medicare Part D.
- I understand that my physician may require supervised administration. Shipment of prescribed medication will be shipped per my physician's request designated on the application.

Fair Credit Reporting Act (FCRA) Authorization

I am providing written instructions authorizing the Foundation and its vendor to obtain my consumer report from a consumer reporting agency to be used solely for the eligibility determination process for programs administered by the Foundation.

(continued on next page)

PATIENT INFORMATION

Name:* **Date of Birth:*** / /

AMGEN SAFETY NET FOUNDATION

OPTIONAL – *Non-commercially insured patients only*

7. PATIENT ASSISTANCE PROGRAM PRE-SCREENING *(Continued)*

THIS SECTION TO BE COMPLETED BY THE PATIENT.

US State Law Consent to Health Data Processing for the Foundation

I consent to the Foundation processing my Health Data for the following purposes:

- To determine my eligibility for and assist with my continued participation in the Foundation.

To contact me to seek feedback on the Foundation's services.

The Foundation uses the following when it administers the program:

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

I understand that my consent to processing is required for me to participate in the program. I also understand that the Foundation will not sell my Health Data to third parties, but the Foundation may disclose my Health Data to the Foundation's data processors, contractors, and business partners for the Foundation's business purposes related to the program. I understand that the Foundation 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 program. Finally, I understand that I may obtain a copy of this consent form or withdraw my consent to the collection, processing and/or disclosure of my Health Data for the above purposes at any time by calling 1-888-401-4931 or by mailing a revocation to 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067, and that if I withdraw my consent, I will no longer be able to participate in the program.

☐ **I CONSENT** ☐ **I DO NOT CONSENT** (Must Choose One)

THIS FORM REQUIRES THE PATIENT'S PRINTED NAME, SIGNATURE AND DATE OF SIGNATURE IN ORDER FOR THE FOUNDATION TO BEGIN PROCESSING THE APPLICATION.
LEGAL REPRESENTATIVE MUST SIGN IF THE PATIENT IS UNDER 18 YEARS OF AGE.

Printed Name of Patient

Printed Name of Legal Representative (if applicable)

Signature of Patient (or legal representative)

Date MM/DD/YYYY

By signing above, I am indicating that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal representative for the Foundation to collect, process, and disclose my Health Data I provide for the purposes described within the Consent above.

IMPORTANT NOTICE: Patients with insurance plans or employers participating in an alternate funding program (also sometimes referred to as patient advocacy programs, or specialty networks) requiring the patient to apply to a manufacture's patient assistance program are not eligible for Amgen Safety Net Foundation.

Patient Authorization

I authorize the Foundation and its contractors and business partners to use and/or disclose my personal information, including my personal health information, for the following purposes:

- To determine my eligibility for and assist with my continued participation in the Foundation.
- To contact me to seek feedback on the Foundation's services.

In order for the Foundation to provide me with the services described above, the Foundation needs to collect and use my personal information, including my personal health information. I understand that my personal 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 ("Health Care Provider"). This may include 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.

Proceed to next page for additional authorization required to complete

PATIENT INFORMATION

Name:* **Date of Birth:*** / /

AMGEN SAFETY NET FOUNDATION

7. PATIENT ASSISTANCE PROGRAM PRE-SCREENING *(Continued)*

THIS SECTION TO BE COMPLETED BY THE PATIENT.

Patient Authorization (continued)

I also authorize and instruct my Health Care Provider(s) to disclose my personal health information to the Foundation, and its contractors and business partners, for the purposes stated above.

I understand that I may refuse to sign this form, but if I refuse to sign it or revoke my authorization, I will not be able to receive assistance from the Foundation. I understand that signing this form is not a condition for receiving any medical care and that my Health Care Provider is not to condition my medical treatment or insurance benefits on my agreement to sign this form.

I understand that once I provide my personal information to the Foundation, and its contractors and business partners, or once my Health Care Provider has provided my personal information to the Foundation, and its contractors and business partners, pursuant to this authorization, federal privacy laws (including HIPAA) may not prevent redisclosure of this information; however, the Foundation, and its contractors and business partners, has agreed to protect my personal information by using and disclosing it only for the purposes described above or as required by law.

I understand that I may receive a copy of this form at any time by contacting the Foundation at 1-888-401-4931 and I may revoke my authorization by mailing a revocation to 2730 S. Edmonds Lane, Suite 300, Lewisville TX 75067 and this is not effective to the extent that action has already been taken based on this authorization.

I understand that this authorization will expire five (5) years after the date it is signed below or one (1) year after the last date I receive medication from the Foundation, whichever is earlier.

I understand and consent to the Foundation contacting me using the contact information provided to enroll me in, operate, and administer the services as described above. I understand that the operation and administration of certain of these services may require that the Foundation contact me by telephone or SMS/text.

THIS FORM REQUIRES THE PATIENT'S PRINTED NAME, SIGNATURE AND DATE OF SIGNATURE IN ORDER FOR THE FOUNDATION TO BEGIN PROCESSING THE APPLICATION.
LEGAL REPRESENTATIVE MUST SIGN IF THE PATIENT IS UNDER 18 YEARS OF AGE.

Printed Name of Patient

Printed Name of Legal Representative (if applicable)

Signature of Patient (or legal representative)

Date MM/DD/YYYY

By signing above, I am indicating that I am legally authorized to consent and that I am providing my consent as the patient or the patient's legal representative for the Foundation to collect, process, and disclose my Health Data I provide for the purposes described within the Authorization above.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please read the following carefully, then date and sign where indicated in Section 6 on page 3.

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 provide me with informational and promotional materials relating to Amgen and AstraZeneca products and services, and/or my condition or treatment; and/or
- 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 (866) 264-2778. 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.

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.

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION *(Continued)*

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. Consent to Health Data Collection & Processing for Marketing Purposes (Optional)

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

- To conduct marketing activities, including market research activities, and to communicate with me regarding products and services that may be of interest to me.

Amgen and AstraZeneca use the following for marketing purposes:

- Health Data – my name, gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that Amgen and AstraZeneca are seeking my consent to collect and process my Health Data to market products and services to me and that I do not have to give consent to the collection and processing of my Health Data for marketing purposes in order to participate in the TEZSPIRE Together program. I also understand that Amgen and AstraZeneca will not sell my Health Data to third parties. If I consent to the collection and processing of my Health Data for marketing purposes, I agree that Amgen and AstraZeneca may contact me for marketing purposes. Finally, I understand that I may withdraw my consent to the collection and processing of my Health Data for marketing purposes at any time using one of the methods listed in the Additional Disclosures section below.

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US STATE LAW CONSENT TO PROCESS HEALTH DATA *(Continued)*

III. Consent to Health Data Disclosure for Marketing Purposes (Optional)

I consent to Amgen and AstraZeneca disclosing my Health Data to their data processors, contractors, and business partners for the following purposes:

- To conduct marketing activities, including market research activities, and to communicate with me regarding products and services that may be of interest to me.

If I provide my consent, Amgen and AstraZeneca will disclose the following for such purposes:

- Health Data – my name, gender, date of birth, contact information and information relating to my health condition or treatment.

I understand that Amgen and AstraZeneca are seeking my consent to disclose my Health Data to their data processors, contractors, and business partners to market products and services to me and that I do not have to give consent to disclosure of my Health Data for marketing purposes in order to participate in TEZSPIRE Together program. I also understand that Amgen and AstraZeneca will not sell my Health Data to third parties. Finally, I understand that I may withdraw my consent to the disclosure of my Health Data for marketing purposes at any time using one of the methods listed in the Additional Disclosures section below.

IV. 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-TZSPIRE (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.

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TEZSPIRE® CO-PAY CARD TERMS & CONDITIONS

SUMMARY OF TERMS AND CONDITIONS

It is important that every patient read and understand the full TEZSPIRE® Co-Pay Card Terms and Conditions. The following summary is not a substitute for reviewing the Terms and Conditions in their entirety.

As further described below, in general:

- The TEZSPIRE Co-Pay Card is open to patients with commercial insurance that covers TEZSPIRE, regardless of financial need. The program is not valid for patients whose TEZSPIRE prescription and/or in-office administration costs are paid for in whole or in part by Medicare, Medicaid, or any other federal or state healthcare program. The TEZSPIRE Co-Pay Card cannot be combined with any other savings, free trial, free goods or similar offer related to TEZSPIRE. It is not valid for cash paying patients or where prohibited by law. (See ELIGIBILITY section in full Terms & Conditions.)The TEZSPIRE Co-Pay Card may help lower your TEZSPIRE out-of-pocket medication and in-office administration costs. Patients who are residents of Massachusetts or Rhode Island are not eligible for injection administration support. Out-of-pocket costs may include co-payment, co-insurance, and deductible out-of-pocket costs. The TEZSPIRE Co-Pay Card does not cover any other costs related to office visits.
- The TEZSPIRE Co-Pay Card provides support up to the Maximum Program Benefit or Patient Total Program Benefit. If a patient's commercial insurance plan imposes different or additional requirements on patients who receive TEZSPIRE Co-Pay Card benefits, Amgen and AstraZeneca have the right to modify or eliminate those benefits. Whether you are eligible to receive the Maximum Program Benefit or Patient Total Program Benefit is determined by the type of plan coverage you have. Please ask your TEZSPIRE Together Co-Pay Program Representative to help you understand eligibility for the TEZSPIRE Co-Pay Card and whether your particular insurance coverage is likely to result in your reaching the Maximum Program Benefit or your Patient Total Program Benefit amount by calling 1-800-818-1770. (See PROGRAM BENEFITS section in full Terms & Conditions.)
- TEZSPIRE patients may pay as little as $0 for each dose of TEZSPIRE medication. They may also receive up to $100 per month for out-of-pocket costs for in-office administration for pre-filled syringe of TEZSPIRE but are responsible for all administration costs that exceed this amount. Patients who are residents of Massachusetts or Rhode Island are not eligible for injection administration support. Amgen and AstraZeneca will pay the remaining eligible TEZSPIRE out-of-pocket costs on behalf of the patient until the Amgen and AstraZeneca payments have reached either the Maximum Program Benefit and/or the Patient Total Program Benefit. Patients are responsible for all amounts that exceed this limit. Please ask your TEZSPIRE Together Co-Pay Program Representative to help you understand eligibility for the TEZSPIRE Together Co-Pay Card by calling 1-800-818-1770. (See PROGRAM BENEFITS and PROGRAM DETAILS sections in full Terms & Conditions.)
- Program coverage through the TEZSPIRE Co-Pay Card is contingent on (1) the submission of the required Explanation of Benefits (EOB) form within 180 days of the date of approval documented on the EOB for medical benefit claims or (2) the submission of the claim within 180 days of the date of service for pharmacy benefit claims. (See PROGRAM DETAILS section in full Terms & Conditions.)

I. ELIGIBILITY

*Eligibility Criteria: Subject to program limitations and terms and conditions, the TEZSPIRE® Co-Pay Card is open to patients who have been prescribed TEZSPIRE and who have commercial or private insurance that covers TEZSPIRE, including state and federal plans commonly referred to as "healthcare exchange plans." This program helps eligible patients cover TEZSPIRE out-of-pocket medication and in-office administration costs, up to program limits. Patients who are residents of Massachusetts or Rhode Island are not eligible for injection administration support. The Co-Pay Card does not cover any other costs related to office visits. There is no income requirement to participate in this program.

This offer is not valid for patients whose TEZSPIRE prescription is paid for in whole or in part by Medicare, Medicaid, or any other federal or state healthcare program. The TEZSPIRE Co-Pay Card cannot be combined with any other savings, free trial, free goods or similar offer related to TEZSPIRE. It is not valid for cash-paying patients or where prohibited by law. A patient is considered cash-paying where the patient has no insurance coverage for TEZSPIRE or where the patient has commercial or private insurance but Amgen and AstraZeneca in their sole discretion determine the patient is effectively uninsured because such coverage does not provide a material level of financial assistance for the cost of a TEZSPIRE prescription. This offer is only valid in the United States, Puerto Rico, and the US territories.

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TEZSPIRE® CO-PAY CARD TERMS & CONDITIONS

SUMMARY OF TERMS AND CONDITIONS *(Continued)*

II. PROGRAM BENEFITS

The TEZSPIRE Co-Pay Card may modify the benefit amount, unilaterally determined by Amgen and AstraZeneca in their sole discretion, to satisfy the out-of-pocket cost sharing requirement for any patient whose plan or plan agent (including, but not limited to, a Pharmacy Benefit Manager (PBM)) requires enrollment in the TEZSPIRE Co-Pay Card as a condition of the plan or PBM waiving some or all of an otherwise applicable patient out-of-pocket cost sharing amount. These programs are often referred to as co-pay maximizer programs. If you believe your commercial insurance plan may have such limitations, please contact the TEZSPIRE Together Co-pay Program at 1-800-818-1770. Health plans and Pharmacy Benefit Managers are prohibited from enrolling or assisting in the enrollment of patients in the TEZSPIRE Co-Pay Card. The patient, or his/her legal representative, must personally enroll in the TEZSPIRE Co-Pay Card in order to be eligible for program benefits.

If at any time a patient begins receiving coverage for medications or in-office administration costs under any federal, state, or government healthcare program (including but not limited to Medicare, Medicaid, TRICARE, Department of Defense, or Veteran Affairs programs), the patient will no longer be able to use this card and must contact the TEZSPIRE Together Co-Pay Program at 1-800-818-1770 (Monday through Friday, from 9AM to 8PM EST) to stop your participation in this program.

Patients may not seek reimbursement for the value received from the TEZSPIRE Co-Pay Card from any third-party payers, including a flexible spending account or healthcare savings account. Participating in this program means that you are ensuring you comply with any required disclosure regarding your participation in the TEZSPIRE Co-Pay Card of your insurance carrier or pharmacy benefit manager. Restrictions may apply. Offer subject to change or discontinuation without notice. This is not health insurance.

III. PROGRAM DETAILS

For all eligible patients the TEZSPIRE® Co-Pay Card offers:

A program benefit that covers the patient's eligible TEZSPIRE out-of-pocket medication and in-office administration costs (may include co-pay, deductible, or co-insurance) on behalf of the patient, up to a Maximum Program Benefit or Patient Total Program Benefit determined by the program per calendar year. The Co-Pay Card does not cover any other costs related to office visits.

TEZSPIRE patients may pay as little as $0 for each dose of TEZSPIRE medication. They may also receive up to $100 per month for out-of-pocket costs for in-office administration of TEZSPIRE (pre-filled syringe only) but are responsible for all administration costs that exceed this amount. Patients who are residents of Massachusetts or Rhode Island are not eligible for injection administration support. Amgen and AstraZeneca will pay the remaining eligible TEZSPIRE out-of-pocket costs on behalf of the patient until the Amgen and AstraZeneca payments have reached either the Maximum Program Benefit or the Patient Total Program Benefit. Patients are responsible for all amounts that exceed this limit.

Program coverage through the TEZSPIRE Co-Pay Card is contingent on (1) the submission of the required Explanation of Benefits (EOB) form within 180 days of the date of approval documented on the EOB for medical benefit claims or (2) the submission of the claim within 180 days of the date of service for pharmacy benefit claims.

Maximum Program Benefit, Patient Total Program Benefit, Benefits May Change, End or Vary Without Notice: The program provides up to a Maximum Program Benefit of support to reduce a patient's out-of-pocket costs that Amgen and AstraZeneca will provide per patient for each calendar year, which must be applied to the TEZSPIRE® patient's out-of-pocket costs (co-pay, deductible, or co-insurance and annual out-of-pocket maximum). Patient Total Program Benefit amounts are unilaterally determined by Amgen and AstraZeneca in their sole discretion and will not exceed the Maximum Program Benefit. The Patient Total Program Benefit may be less than the Maximum Program Benefit, depending on the terms of a patient's plan, and may vary among individual patients covered by different plans, based on factors determined solely by Amgen and AstraZeneca, to ensure all program funds are used for the benefit of the patient. Each patient is responsible for costs above the Patient Total Program Benefit amounts. Please ask your TEZSPIRE Together Co-pay Program Representative to help you understand whether your particular insurance coverage is likely to result in your reaching the Maximum Program Benefit or your Patient Total Program Benefit amount by calling 1-800-818-1770. Participating patients are solely responsible for updating Amgen and AstraZeneca with changes to their insurance including, but not limited to, initiation of insurance provided by the government,

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the addition of any coverage terms that do not apply TEZSPIRE Co-Pay Card benefits to reduce a patient's out-of-pocket costs, such as accumulator adjustment benefit design or a co-pay maximization program. Participating patients are responsible for providing Amgen and AstraZeneca with accurate information necessary to determine program eligibility. By accepting payments from Amgen and AstraZeneca made on behalf of participating patients, participating PBMs and Plans likewise are responsible for providing Amgen and AstraZeneca with accurate information regarding patient eligibility.

Patients may use the card every time they receive a prescription fill or dose of TEZSPIRE, up to the Maximum Program Benefit or Patient Total Program Benefit.

Benefits reset each calendar year. Re-enrollment in the program is required at regular intervals. Patients may continue in the program as long as patient re-enrolls as required by Amgen and AstraZeneca and continues to meet all of the program's eligibility requirements during participation in the program. Patients can enroll/re-enroll by going to copay.TEZSPIRETogether.com or by calling 1-800-818-1770.

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