TEZSPIRE® (tezepelumab-ekko) Subcutaneous Injection 210 mg | TEZSPIRE® together Powered by AMGEN Support+

Program Enrollment Form

Fill in this form **ONLINE** at TEZSPIRETogetherHCP.com, or **COMPLETE** all fields below, then **FAX** pages 1-3 to **1-888-388-6016.**

THIS SECTION TO BE COMPLETED AND SIGNED BY THE PATIENT OR LEGAL REPRESENTATIVE

1 PATIENT INFORMATION

An asterisk (*) indicates a required field.

First Name:* _____ Last Name:* _____

Date of Birth:* ____ / ____ / _____ Sex:* ☐ Male ☐ Female ☐ Not Specified

Street:* _____ City:* _____ State:* _____ ZIP Code:* _____

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: _____ City: _____ State: _____ ZIP Code: _____

Email: _____ Phone:* _____ ☐ Home ☐ Mobile

Preferred Language (if not English): _____ Preferred Form of Communication: ☐ Text ☐ Email

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

Full Name: _____ Phone: _____ Email: _____

OPTIONAL Affordability Screening (non-commercially insured patients only)

To see if you might qualify for additional affordability options, please complete the information below.

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 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.

TELEPHONE CONSUMER PROTECT ACT (TCPA) CONSENT

☐ I have read the Telephone Consumer Protection Act (TCPA) on page 4 and consent to receive messages from Amgen and AstraZeneca.

CONSENT TO HEALTH DATA PROCESSING FOR TEZSPIRE TOGETHER*

You must read the Consent to Health Data Processing on pages 4-5 and then select one of the below responses. 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 and Co-pay Card Programs.

☐ I consent to the collection, processing, and disclosure of my Health Data for the purposes set forth on pages 4-5.

☐ I do not consent to the collection, processing, or disclosure of my Health Data for the purposes set forth on pages 4-5.

TEZSPIRE TOGETHER FAST START PROGRAM TERMS & CONDITIONS (COMMERCIALLY INSURED PATIENTS ONLY)*

☐ By checking this box, I agree that I have read, understand, and accept the Terms & Conditions of the Fast Start Program on page 5.

TEZSPIRE TOGETHER CO-PAY PROGRAM TERMS & CONDITIONS (COMMERCIALLY INSURED PATIENTS ONLY)*

To check eligibility for the Co-pay Program, you must have commercial insurance and you must answer the questions below, agree to the Terms & Conditions by checking the box below, and agree to the Patient Authorization by signing below.

☐ By checking this box, I agree that I have read, understand, and accept the Terms & Conditions of the Co-pay Card Program on pages 5-6.

REQUIRED (If enrolling in co-pay)

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

☐ Yes ☐ No ☐ I don't know

Do you have Medicare A and B but with a commercial pharmacy benefit?

☐ Yes ☐ No ☐ I don't know

PATIENT AUTHORIZATION – REQUIRED

I have read and agree to the Authorization for Use and Disclosure of Protected Health Information on page 4 and understand that I must sign below to participate in the TEZSPIRE Together Fast Start and Co-pay Card Programs. Legal representative is required if patient is younger than 18 years of age.

Signature of Patient/Legal Representative:* ▶ _____

Name of Patient/Legal Representative:* ▶ _____

Today's Date:* ____ / ____ / _____

Print Full Name: _____
(If signed by Legal Representative)

Relationship to Patient: _____
(Required if patient is under the age of 18)

Please **COMPLETE** and **FAX** pages 1-3 to **1-888-388-6016**. For additional assistance, **CALL 1-888-TZSPIRE (1-888-897-7473)**, 8 AM – 8 PM ET, Monday – Friday. Please visit TEZSPIRETogetherHCP.com for additional resources.

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Program Enrollment Form

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

THIS PAGE TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

2 SERVICES REQUESTED (Select all that apply)

An asterisk (*) indicates a required field.

- ☐ **Benefits Verification (BV):** Verify the patient's insurance coverage and determine the patient's out-of-pocket costs for TEZSPIRE.**
- ☐ **Prior Authorization (PA) and Appeals Support:** Identify the PA and appeals requirements based on plan criteria and track the status of a submission.
- ☐ **Specialty Pharmacy Triage:** The TEZSPIRE Together Hub will triage the prescription to the appropriate specialty pharmacy based on patient benefits.
- ☐ **Fast Start Enrollment:** Help your eligible commercial patient get started on TEZSPIRE before submitting PA paperwork. Complete Section 7 and confirm the patient has completed Section 1. See full Terms & Conditions on page 5. By checking this box, I agree that the PA will be submitted within 30 days of the first Fast Start shipment. Additionally, if the PA is denied, I agree that an appeal will be submitted within 30 days of denial. Noncompliance with these terms will result in the patient no longer being eligible for the Fast Start Program.
- ☐ **Co-pay Enrollment:** Help your eligible commercially insured patients reduce their out-of-pocket expenses for TEZSPIRE. Please confirm that the patient has completed Section 1. See full Terms & Conditions on pages 5-6.

**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 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/

3 PRODUCT SELECTION & ACQUISITION*

☐ Check this box to request a **BV be run for both the pre-filled syringe and pre-filled pen** simultaneously to identify the coverage option that may result in the lowest out-of-pocket cost for the patient. **Choose the administration site for each formulation below.**

If you choose not to check the above box, then check the formulation below for which you want a BV run or both. If selecting both, indicate 1st preference and 2nd preference (a BV for the 2nd preference will only be run if the 1st formulation preference results in no coverage). Check the administration site and acquisition method.

Product Formulation	Preference	Administration Site	Acquisition Method
☐ Pre-filled syringe	☐ 1st ☐ 2nd	☐ HCP office ☐ Hospital/Infusion center	☐ Buy & Bill ☐ Specialty Pharmacy
☐ Pre-filled pen	☐ 1st ☐ 2nd	☐ Patient administered	☐ Specialty Pharmacy

Preferred Specialty Pharmacy _____

4 INSURANCE INFORMATION

☐ **Commercial/Private Insurance** ☐ **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.

If your patient is uninsured, please make sure they complete the affordability screening section on page 1, or ask them to call 1-888-897-7473 to determine if they 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:*

5 CLINICAL INFORMATION – DO NOT ATTACH CLINICAL NOTES

ICD-10-CM Code:* ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ Other/Miscellaneous: _____

☐ **Known Drug Allergies:*** _____ ☐ **No Known Drug Allergies**

Please **COMPLETE** and **FAX** pages 1-3 to **1-888-388-6016**. For additional assistance, **CALL 1-888-TZSPIRE (1-888-897-7473)**, 8 AM – 8 PM ET, Monday – Friday. Please visit TEZSPIRETogetherHCP.com for additional resources.

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Program Enrollment Form

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

THIS PAGE TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

6 PRESCRIBER INFORMATION

An asterisk (*) indicates a required field.

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:* _____

7 PRESCRIPTION INFORMATION

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

Please complete the pharmacy and Fast Start prescription(s) for your first and second preference, if applicable. If you have requested transfer of the prescription to a Specialty Pharmacy, TEZSPIRE Together will transfer the prescription for the first preference if coverage is available. If coverage for the first preference is not available, the prescription for the second preference will be transferred.

PRE-FILLED SYRINGE

☐ **TEZSPIRE (tezepelumab-ekko)** 210 mg/1.91 mL (110 mg/mL) single-dose pre-filled syringe injection

SIG: Inject 210 mg SC once every 4 weeks
HCP Administration (NDC: 55513-0112-01)
Quantity Dispensed: 1 **Refills:*** ___

PRE-FILLED PEN

☐ **TEZSPIRE (tezepelumab-ekko)** 210 mg/1.91 mL (110 mg/mL) single-dose pre-filled pen injection

SIG: Inject 210 mg SC once every 4 weeks as directed by physician
Self-Administration (NDC: 55513-0123-01)
Quantity Dispensed: 1 **Refills:*** ___

FAST START PRESCRIPTION (If Fast Start is requested)

☐ **Fast Start Program:** By checking this box, I acknowledge that I have read, understand, and agree to the Fast Start Program requirements set forth in Section 2 "Services Requested" on page 2.

☐ **TEZSPIRE (tezepelumab-ekko)** 210 mg/1.91 mL (110 mg/mL) single-dose pre-filled syringe injection

SIG: Inject 210 mg SC once every 4 weeks
HCP Administration (NDC: 55513-0112-01)
Quantity Dispensed: 1 **Refills:** 11

☐ **TEZSPIRE (tezepelumab-ekko)** 210 mg/1.91 mL (110 mg/mL) single-dose pre-filled pen injection

SIG: Inject 210 mg SC once every 4 weeks as directed by physician
Self-Administration (NDC: 55513-0123-01)
Quantity Dispensed: 1 **Refills:** 11

REQUIRED if the shipping address is different than the prescriber's address in Section 6.

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: _____

Prescriber Signature (Substitution permitted): _____ Date: _____

Please **COMPLETE** and **FAX** pages 1-3 to **1-888-388-6016**. For additional assistance, **CALL 1-888-TZSPIRE (1-888-897-7473)**, 8 AM – 8 PM ET, Monday – Friday. Please visit TEZSPIRETogetherHCP.com for additional resources.

PATIENT TO RETAIN PAGES 4-6

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please read the following carefully, then date and sign where indicated in Section 1 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; 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 or by writing to Cardinal Health Specialty Solutions, 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067. 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.

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.

TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT (REQUIRED FOR TEXT COMMUNICATIONS ONLY)

In addition to the patient authorization consent, I understand that I consent to Amgen and AstraZeneca calling and texting me at the phone number(s) I have provided with promotional communications relating to Amgen and AstraZeneca products and services and/or my condition or treatment. Amgen and AstraZeneca may use automatic dialing machines or artificial or prerecorded messages to contact me and may leave a voicemail or SMS/text message (standard text messaging rates may apply). I understand that I am not required to provide this consent as a condition of purchasing any goods or services. Reply STOP to cancel SMS messages.

U.S. 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.

PATIENT TO RETAIN PAGES 4-6

U.S. STATE LAW CONSENT TO PROCESS HEALTH DATA (CONTINUED)

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-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.

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.)
- 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.)

TEZSPIRE® CO-PAY CARD TERMS & CONDITIONS (CONTINUED)

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.

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, 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**.

AMGEN® AstraZeneca