TEZSPIRE® (tezepelumab-ekko) Subcutaneous Injection 210 mg | TEZSPIRE® together

Program Enrollment Form

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:** _____

We use text or email to send necessary communications regarding our programs, including co-pay card details (if eligible). If these options are not available, we will send communications through direct mail.

Email:* _____ **Phone:*** _____ ☐ Home ☐ Mobile

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

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

☐ In addition to the below patient authorization consent, I understand that by checking this box and signing below, 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.

PATIENT AUTHORIZATION

I have read and agree to the Authorization to Use and Disclose Personal Information on page 5. You 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:* ____ / ____ / _____

Legal Representative Phone (if different from above): _____ **Relationship to Patient:** _____

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

If you have commercial insurance and your health plan requires a prior authorization or does not cover TEZSPIRE (pre-filled syringe only), you may be eligible to receive TEZSPIRE free for up to twelve (12) doses within twenty-four (24) months from the date the first dose is filled. See full Terms & Conditions on pages 5-6.

▶ ☐ **By checking this box, I agree that I have read, understand, and accept the Terms & Conditions of the Fast Start Program on pages 5-6.**

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

To check eligibility for the Co-pay Card Program, you must have commercial insurance and you must **answer the question below, agree to the Terms & Conditions, and sign the Patient Authorization above**.

Are you eligible for Medicare but receive prescription drug coverage from a former employer, union, or welfare plan?: ☐ Yes ☐ No ☐ I don't know

▶ ☐ **By checking this box, I agree that I have read, understand, and accept the Terms & Conditions of the Co-pay Card Program on pages 6-7.**

Please see Indication and Important Safety Information on Page 8.

Please **COMPLETE** and **FAX** pages 1-4 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.

USA-157-80715

TEZSPIRE® (tezepelumab-ekko) Subcutaneous Injection 210 mg | TEZSPIRE® together

Program Enrollment Form

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

THIS PAGE TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

2 INSURANCE INFORMATION

An asterisk (*) indicates a required field.

☐ **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 ask them to call 1-888-897-7473 to determine if they qualify for assistance through the TEZSPIRE Patient Assistance Program.

	Primary Medical Insurance	Pharmacy Insurance		Secondary Medical Insurance
Insurance Provider				
Insurance Phone				
Cardholder Name (if not the patient)				
Cardholder Date of Birth				
Policy ID				
Group #				
RxBIN/RxPCN	X	RxBIN:	RxPCN:	X

3 PRODUCT SELECTION & ACQUISITION

TEZSPIRE is available in 2 formulations, a pre-filled syringe for HCP administration and a pre-filled pen for self-administration.

Please select the primary and secondary formulation preference.

Primary Option:* ☐ Pre-filled syringe (HCP administration) ☐ Pre-filled pen (self-administration)

Secondary Option:* ☐ Pre-filled syringe (HCP administration) ☐ Pre-filled pen (self-administration) ☐ Do not pursue a second option

Please answer the questions below if you have a preference for the pre-filled syringe formulation.

How will you obtain TEZSPIRE pre-filled syringe?* ☐ Buy & Bill ☐ Specialty Pharmacy

Preferred Specialty Pharmacy _____

Where will your patient receive their injections?* ☐ Healthcare Provider Office ☐ Hospital Outpatient/Infusion Center ☐ N/A

Please see Indication and Important Safety Information on Page 8.

Please **COMPLETE** and **FAX** pages 1-4 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.

USA-157-80715

TEZSPIRE® (tezepelumab-ekko) Subcutaneous Injection 210 mg | TEZSPIRE® together

Program Enrollment Form

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

THIS PAGE TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

4 PROGRAM SERVICES

An asterisk (*) indicates a required field.

TEZSPIRE Together Service Request (check all that apply):

- ☐ **Benefits Verification:** Verify your patient's insurance coverage for TEZSPIRE. TEZSPIRE Together will run a Benefits Verification for the preferred formulation. In the event the preferred formulation is not covered, a Benefits Verification will be run for the second option, if applicable.
- ☐ **Transfer to Specialty Pharmacy:** TEZSPIRE Together will transfer your patient's prescription to the preferred or mandated Specialty Pharmacy. Please complete Section 7 and ensure the Pharmacy Insurance information is completed in Section 2.
- ☐ **Prior Authorization (PA) and Appeals Support:** Identify the PA and appeal requirements based on plan criteria and track the status of a submission.
- ☐ **Co-pay Program:** Help your eligible commercially insured patients enroll in the TEZSPIRE Together Co-pay Program and reduce their out-of-pocket costs for both TEZSPIRE medication and HCP administration. Please ensure the patient has agreed to the Co-pay Program Terms and Conditions on page 1.
- ☐ **Fast Start Program:** The Fast Start Program provides up to 12 doses of the pre-filled pen or pre-filled syringe at no cost to eligible commercially insured patients whose plan requires a PA or does not cover TEZSPIRE (pre-filled syringe only). For immediate enrollment in Fast Start, please complete the Fast Start Prescription in Section 7, check the box for Fast Start, and confirm the patient has completed Section 1.

  By checking this box, I acknowledge that the PA must be submitted within 30 days of the first Fast Start shipment. Additionally, if the PA is denied, an appeal must 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. 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.

Please provide the address to which the Fast Start pre-filled syringe (HCP administration) should be shipped if different than the prescriber's address in Section 6. Fast Start doses of the pre-filled pen for self-administration will be shipped to the patient's address provided on page 1.

Site Name:* _____ Site NPI:* _____

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

5 CLINICAL INFORMATION

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

Known Drug Allergies:* _____

6 PRESCRIBER INFORMATION

Prescriber Name:* _____ Office Contact Name: _____

Prescriber NPI #:* _____ Office Contact Email: _____

Site NPI #:* _____ Practice/Clinic Name: _____

Tax ID #:* _____

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

Medicare Provider # (PTAN):* _____ Phone:* _____ Fax:* _____

Medicaid Provider #: _____

Please see Indication and Important Safety Information on Page 8.

Please **COMPLETE** and **FAX** pages 1-4 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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TEZSPIRE® (tezepelumab-ekko) Subcutaneous Injection 210 mg | TEZSPIRE® together

Program Enrollment Form

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

THIS PAGE TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

7 PRESCRIPTION INFORMATION

An asterisk (*) indicates a required field.

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.

SPECIALTY PHARMACY PRESCRIPTION

☐ **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: 55513-112-01)

Quantity Dispensed:* 1 **Refills:*** ___

☐ **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:*** ___

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.

Dispense as Written/Brand Medically Necessary/Do Not Substitute/ No Substitution/May Not Substitute

Prescriber Signature (dispense as written): **Today's Date:**

May Substitute/Product Selection Permitted/Submission Permissible

Prescriber Signature (substitution permitted): **Today's Date:**

FAST START PRESCRIPTION

Fast Start is an optional program that provides up to 12 free doses of TEZSPIRE to eligible commercially insured patients whose plan requires a PA or does not cover TEZSPIRE (pre-filled syringe only).

☐ **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: 55513-112-01)

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

Dispense as Written/Brand Medically Necessary/Do Not Substitute/ No Substitution/May Not Substitute

Prescriber Signature (dispense as written): **Today's Date:**

May Substitute/Product Selection Permitted/Submission Permissible

Prescriber Signature (substitution permitted): **Today's Date:**

Please see Indication and Important Safety Information on Page 8.

Please **COMPLETE** and **FAX** pages 1-4 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.

USA-157-80715

PATIENT TO RETAIN PAGES 5-7

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

Uses and Disclosure of Personal Information

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

I authorize Amgen, AstraZeneca Pharmaceuticals LP, and their contractors and business partners ("Amgen and AstraZeneca") to use and/or disclose my personal information, including my personal health information, only 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 healthcare 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, conduct, and evaluate products, services, materials, outcomes/scientific research, and programs related to my condition or treatment
- Outcomes/scientific research purposes which includes contacting me to participate in focus groups, surveys, research, or interviews. 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 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 healthcare provider, healthcare plan, pharmacy, pharmaceutical company, laboratory, and/or their contractor ("Healthcare Provider"). This may include select information from or about my medical history and general health, my healthcare plan benefits, payment limits or restrictions covered by my healthcare plan policy, and/or my adherence to my treatment

I authorize my Healthcare Providers to disclose my personal 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 Healthcare Providers (such as pharmacies and specialty pharmacies) may receive remuneration from Amgen and AstraZeneca in exchange for disclosing my personal 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.

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

I understand that by signing this form, I authorize my Healthcare Providers or others who might hold my health information to only release it to Amgen and AstraZeneca employees, as well as to their contractors and business partners, who are performing the services set forth in this Authorization. I also understand I am authorizing my personal information, including my personal 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 release my personal health information for the earlier of five (5) years or until my participation in the program 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) or by writing to Cardinal Health Specialty Solutions, 2730 S Edmonds Lane, Suite 300, Lewisville, TX 75067. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Healthcare Provider is disclosing my personal health information to Amgen and AstraZeneca on an authorized on-going basis, my cancellation with Amgen and AstraZeneca will be effective with respect to any such Healthcare Providers as soon as they receive notice of my cancellation.

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 Healthcare 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 this information from my Healthcare Providers. I understand I cannot participate in the listed services and/or programs without signing this Authorization or an equivalent authorization with my Healthcare Providers.

Information Received From Healthcare Providers

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

Authorization to Contact

I understand and consent to Amgen and AstraZeneca contacting me using the contact information provided in this form to enroll me in, operate, and administer Amgen and AstraZeneca patient support services and/or programs as described above other than promotional communications by telephone or SMS/text. I understand that the operation and administration of certain of these services and/or programs may require that Amgen and AstraZeneca contact me by telephone or SMS/text.

Safety Reporting Follow-up

I understand that for safety reporting purposes, the safety department of AstraZeneca or its trusted processors may contact me for follow-up for the reporting of any adverse events or other safety findings.

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.

Please see Indication and Important Safety Information on Page 8.

TEZSPIRE® FAST START PROGRAM TERMS & CONDITIONS (CONTINUED)

Pre-filled Syringe

- **If the patient was prescribed the pre-filled syringe and the patient's plan does not cover TEZSPIRE or requires a prior authorization,** the patient can receive TEZSPIRE free for up to twelve (12) doses 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.

Pre-filled Pen

- **If the patient was prescribed the pre-filled pen and the patient's plan covers TEZSPIRE on formulary but requires a prior authorization,** the patient can receive TEZSPIRE free for up to twelve (12) doses 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.

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 below.)
- 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 reduce or eliminate Co-Pay Card 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 Representative to help you understand eligibility for the TEZSPIRE Co-Pay Card and whether your insurance coverage is likely to result in you reaching the Maximum Program Benefit or your Patient Total Program Benefit amount by calling 1-888-TZSPIRE (1-888-897-7473). (See PROGRAM BENEFITS section below.)
- 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 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. Please ask your TEZSPIRE Together Representative to help you understand eligibility for the TEZSPIRE Co-Pay Card by calling 1-888-TZSPIRE (1-888-897-7473). (See PROGRAM BENEFITS and PROGRAM DETAILS sections below).
- Program coverage through the TEZSPIRE Co-Pay Card is contingent on the submission of the required Explanation of Benefits (EOB) form (where applicable) within 180 days of the date of service. (See PROGRAM DETAILS section below.)

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.

Please see Indication and Important Safety Information on Page 8.

TEZSPIRE CO-PAY CARD TERMS & CONDITIONS (CONTINUED)

II. PROGRAM BENEFITS

The TEZSPIRE® Co-Pay Card does not cover TEZSPIRE out-of-pocket costs for any patient whose selected coverage option under their commercial insurance plan does not apply TEZSPIRE Co-Pay Card payments to satisfy the patient's co-payment, deductible, or co-insurance for TEZSPIRE medication or in-office administration costs. Patients with these plan limitations are not eligible for the TEZSPIRE Co-Pay Card but may be eligible for other needs-based assistance provided by Amgen and AstraZeneca. These programs are often referred to as accumulator adjustment programs. **If you believe your commercial insurance plan may have such limitations, please contact TEZSPIRE Together at 1-888-TZSPIRE (1-888-897-7473).**

The TEZSPIRE Co-Pay Card also may provide a reduced Co-Pay Card 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 TEZSPIRE Together at 1-888-TZSPIRE (1-888-897-7473).**

Health plans, Specialty Pharmacies, and Pharmacy Benefit Managers (individually and collectively "Plan Administrators") are prohibited from enrolling patients in the TEZSPIRE Co-Pay Card. Plan Administrators are prohibited from assisting patients with enrollment 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 TEZSPIRE Together at **1-888-TZSPIRE (1-888-897-7473)** (Monday through Friday, from 8 AM to 8 PM ET) 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, and 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 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.

Program coverage through the TEZSPIRE Co-Pay Card is contingent on the submission of the required Explanation of Benefits (EOB) form (where applicable) within 180 days of the date of service.

Maximum Program Benefit, Patient Total Program Benefit, Benefits May Change, End or Vary: 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). **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 programs 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 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 **1-888-TZSPIRE (1-888-897-7473)**. 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 dose of TEZSPIRE. Benefits reset each calendar year. Re-enrollment in the program is required at regular intervals. Patients may participate in the program as long as s/he re-enrolls as required by Amgen and AstraZeneca and s/he continues to meet all the program's eligibility requirements during participation in the program. Patients can enroll/re-enroll by going to TEZSPIRETogether.com or by calling **1-888-TZSPIRE (1-888-897-7473)**.

FOR PATIENTS ENROLLING IN THE TEZSPIRE TOGETHER CO-PAY PROGRAM:

1 Once you've successfully enrolled, you'll receive a welcome communication via text or email that explains **how to access your Co-pay Card details.**

2 **Please make sure to read your welcome communication** and follow the steps provided. Links on emails and text messages will only remain active for **90 days**.

Please see Indication and Important Safety Information on Page 8.

USA-157-80715

INDICATION

TEZSPIRE is indicated for the add-on maintenance treatment of adult and pediatric patients aged 12 years and older with severe asthma.

TEZSPIRE is not indicated for the relief of acute bronchospasm or status asthmaticus.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

Known hypersensitivity to tezepelumab-ekko or excipients.

WARNINGS AND PRECAUTIONS

Hypersensitivity Reactions

Hypersensitivity reactions were observed in the clinical trials (eg, rash and allergic conjunctivitis) following the administration of TEZSPIRE. Postmarketing cases of anaphylaxis have been reported. These reactions can occur within hours of administration, but in some instances have a delayed onset (ie, days). In the event of a hypersensitivity reaction, consider the benefits and risks for the individual patient to determine whether to continue or discontinue treatment with TEZSPIRE.

Acute Asthma Symptoms or Deteriorating Disease

TEZSPIRE should not be used to treat acute asthma symptoms, acute exacerbations, acute bronchospasm, or status asthmaticus.

Abrupt Reduction of Corticosteroid Dosage

Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with TEZSPIRE. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a physician. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.

Parasitic (Helminth) Infection

It is unknown if TEZSPIRE will influence a patient's response against helminth infections. Treat patients with pre-existing helminth infections before initiating therapy with TEZSPIRE. If patients become infected while receiving TEZSPIRE and do not respond to anti-helminth treatment, discontinue TEZSPIRE until infection resolves.

Live Attenuated Vaccines

The concomitant use of TEZSPIRE and live attenuated vaccines has not been evaluated. The use of live attenuated vaccines should be avoided in patients receiving TEZSPIRE.

ADVERSE REACTIONS

The most common adverse reactions (incidence ≥3%) are pharyngitis, arthralgia, and back pain.

USE IN SPECIFIC POPULATIONS

There are no available data on TEZSPIRE use in pregnant women to evaluate for any drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. Placental transfer of monoclonal antibodies such as tezepelumab-ekko is greater during the third trimester of pregnancy; therefore, potential effects on a fetus are likely to be greater during the third trimester of pregnancy.

Full Prescribing Information including Patient Information and Instructions for Use.

You may report side effects related to AstraZeneca products by clicking here.

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