

Please visit www.Toprol-XLDirect.com for full program details or to enroll online.

Mail your completed form to AstraZeneca Direct, c/o Eagle Pharmacy,
PO Box 90789, Lakeland, FL 33804

Contact information

Name _____
First Middle Initial Last

Date of birth (MM/DD/YYYY) ____/____/____ Gender Male Female

Shipping address _____

City _____ State _____ Zip _____

Primary phone number (____) _____ E-mail _____

How did you hear about us? _____

Do you have insurance? Private Insurance Medicare Part D Medicaid/Government Insurance None

Prescription medication information

In order to complete your enrollment, a valid prescription is required. Remember to write your date of birth on your prescription. Please select one of the check boxes below.

- I will send my prescription with this form to: AstraZeneca Direct, c/o Eagle Pharmacy, PO Box 90789, Lakeland, FL 33804
- My physician will fax to 877-283-9172 or call 855-900-0779. (Please note that only prescribers may fax or call in prescriptions to a pharmacy)
- My physician sent my prescription electronically to Eagle Pharmacy via e-prescribing

Physician's full name _____

Physician's office phone number (____) _____ Physician's office fax number (____) _____

Prescription Refills: There are two ways to receive your refills. To place a refill order over the phone, please call 1-855-900-0779 approximately three weeks prior to when you want to receive your refill. Or enroll in our auto-refill option.

- Check this box to enroll in auto-refills and have future prescription refills shipped automatically. Your refills will be shipped to your shipping address and billed to your credit card on file.

Medical history information

We collect this information to help ensure the safety of our patients. It is your responsibility to fill this section out accurately.

Drug allergies. Mark all that apply.

- I have no known drug allergies Codeine Aspirin Penicillin Erythromycin
- Tetracyclines Cephalosporins Amoxicillin Sulfa Other allergy _____

Health conditions. Mark all that apply.

- I have no listed conditions Asthma High cholesterol/heart disease COPD Renal disease
- Depression Liver disease Diabetes GERD/Ulcer Hypertension Bleeding disorder
- Other health condition _____

Other medication.

Please provide all other prescription, over-the-counter, and herbal/vitamin supplements you are taking. _____ I do not take any other medications or supplements.

Payment and billing information

Billing address _____

Same as shipping address City _____ State _____ Zip _____

Name as it appears on the card _____

Credit card type: Visa Mastercard Amex Discover Credit card number _____

Expiration date (MM/YYYY) ____/____ 30 tablets \$15 90 tablets \$30

- I understand and certify that this program is not available for prescriptions purchased under Medicaid or similar state or federal government programs. Medicare Part D prescription orders will be processed without using Part D or other insurance and cannot be applied to true-out-of-pocket (TrOOP) cost. I authorize the program to fill prescription without using my insurance benefits and agree that I will not seek reimbursement from, or apply the cost toward, any insurance benefit
- By providing my billing information, I authorize my credit card to be charged the proper amount, whether determined by my insurance or via a non-insurance alternative
- This program offers brand-name medications and as such I elect to receive branded product. No generic substitution will be made. Should I wish to receive a generic product in the future, I will call 1-855-900-0779
- By enrolling in AstraZeneca Direct, I grant AstraZeneca Pharmaceuticals permission to provide me with information about this product and program, and other products, programs, and services that may be of interest to me, such as money-saving offers, patient education, and other resources. I am aware that Eagle Pharmacy will provide my contact information to AstraZeneca Pharmaceuticals. If in the future I no longer want to receive these materials, I will contact AstraZeneca at 1-800-236-9933
- I understand that the program will only use my information to decide if I qualify to participate in the program; administer or improve the program; communicate with insurance plans, including Medicare Part D plans; share my information with the Centers for Medicare and Medicaid Services
- AstraZeneca reserves the right to change or discontinue this offer at any time without notice

Signature _____

AstraZeneca Direct: Delivering brand name medications directly to patients

TOPROL-XL Direct is part of the AstraZeneca Direct program. Your prescription will be processed and handled by the AstraZeneca Direct trusted pharmacy administrator, Eagle Pharmacy. Eagle Pharmacy is staffed by registered pharmacists and certified pharmacy technicians.