

AstraZeneca introduces...

ARIMIDEX Direct

ARIMIDEX sent directly to your home for **\$40** per month

ENROLLMENT FORM

To enroll in ARIMIDEX Direct, complete the information and mail the enrollment form, along with your prescription to the address below.

AstraZeneca respects your personal health information. The information you provide may be used to send you health-related materials and to develop products, services, and Programs. AstraZeneca, or third parties working on our behalf, will not sell or rent personal health information. To report a medication side effect, or if in the future you want to withdraw from the Program and cancel your permission to use your information, call 1-800-236-9933. Please visit www.azprivacystatement.com to review our Privacy Statement.

Personal Information

Name: _____
First Middle Initial Last

Phone: (____) _____ Date of Birth (mm/dd/yyyy): ____/____/____

Address: _____

City: _____ State: _____ Zip _____

List any medications you are taking: _____

List any medications you are allergic to: _____

Doctor's Name: _____ Phone: (____) _____

Order and Payment Information

Please indicate order quantity: 30-day supply for \$40 90-day supply for \$120

By money order: Please make money order payable to AstraZeneca Direct to Patient.
Please do not send cash.

By Credit Card: Please check one

Credit card type: Visa MasterCard Discover

Credit Card Number: _____ - _____ - _____ - _____ Expiration Date: ____/____

I authorize AstraZeneca and their affiliates to charge this card for payment on the order indicated above.

Name on card (PRINT): _____

Signature of cardholder: _____
(Required if using credit card)

Billing Address: Is it different from personal address? If yes, complete section below:

Address: _____

City: _____ State: _____ Zip _____

Consent

(ALL enrollees must complete this section)

I give the Program, the Program administrators, and my doctor permission to:

- Share my information with the pharmacists that may supply my medicine or people helping with the Program
- Contact me by mail or phone about the Program and about other products, programs, or services that might interest me
- I will not seek reimbursement of any fee I pay to AstraZeneca from my health insurance, including Medicaid, Medicare or similar programs.
- Contact me in order to make sure that I have received the medicines sent by the Program

Signature of Applicant

X _____

Date: ____/____/____

AstraZeneca reserves the right to rescind, revoke or amend the program without notice at any time.

Attach your ARIMIDEX prescription here

Mail your completed enrollment form and your prescription for ARIMIDEX to:

AstraZeneca Direct to Patient

PO BOX 66976

St. Louis, MO 63166-6976

OR have your health care provider fax your enrollment form and prescription to 800-698-3759.

For more information, call 800-637-3616 Monday through Friday, 8:00 AM to 6:00 PM ET.

Arimidex[®]
anastrozole 1 mg
tablets