NOVARTIS

Novartis Patient Assistance Foundation, Inc.

www.PAP.Novartis.com
Phone: 1-(800)-277-2254 Fax: 1-(855)-817-2711
P.O. Box 52029, Phoenix, AZ 85072-2029
Monday-Friday 8:00 a.m. to 8:00 p.m. Eastern Time Zone

For a complete list of medications and income requirements to see if you are eligible, please visit www.PAP.Novartis.com

To be eligible, a patient must:

- Reside in the United States or a U.S. Territory
- Have limited or no prescription insurance coverage
- Meet income guidelines for the medication for which the patient is seeking assistance. Visit www.PAP.Novartis.com
- Have a valid prescription for the Novartis medication
- Be treated by a licensed U.S. healthcare provider on an outpatient basis

Patient Instructions

- ☐ Check www.PAP.Novartis.com to see if you may be eligible for the program.
- ☐ Check your application and make sure all the blanks are filled in or mark N/A.
- ☐ Include copies of the front and back of ALL your insurance cards.
  - If you have any Medicare plan, please provide your traditional Medicare Red/White/Blue card along with all other Part D or Advantage plan ID cards.
- ☐ Include copies of the first two pages of your latest Federal Income Tax Return.
- ☐ Read Section 4 and check the box if you want prescription updates and reminders for NPAF via phone or text.
- ☐ Read the Patient Authorization on page 2
  - It describes what data NPAF collects and how it will be used. NPAF can't enroll you in the PAP program without some medical information from your doctor. You need to give your doctor permission to share that information with NPAF.
- ☐ Sign and date Section 5
  - Your signature is not required for treatment by your doctors, but it is required if you want to participate in the PAP program. We need it to process your application.

Prescriber Instructions

- ☐ Complete and fax the Prescriber Application Page.
- ☐ Prescriber must fax separate prescription along with the Prescriber Application.
- ☐ Manage any Prior Authorization (PA) that is required by insurance companies.
  - Include all PA and Appeal results with the Prescriber's application submission.
- ☐ Read the attestation, sign and date the form.

Applications MUST be filled out completely and accurately.
Any missing information will result in a processing delay or application denial.

Fax or mail your completed application to:
Fax: **1-(855)-817-2711** **—OR—** Mail: **NPAF, P.O. Box 52029, Phoenix, AZ 85072-2029**

PLEASE KEEP THIS PAGE FOR YOUR RECORDS.

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Patient Authorization

I give permission for my health care providers (HCPs), pharmacies, service providers and their contractors ("Health Care Providers"), health insurer(s) and their contractors ("Insurers"), to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to the Novartis Patient Assistance Foundation, Inc. ("NPAF") so that NPAF can administer the NPAF program by: (i) providing me with access to the product which I am prescribed, (ii) helping to verify insurance coverage, (iii) providing me with information about Novartis products, (iv) providing me with medication reminders, and (v) conducting quality assurance, surveys, and/or other internal business activities in connection with the NPAF program.

I give permission to NPAF to disclose my Personal Information to my Health Care Providers, Insurer(s), caregivers, Novartis Pharmaceuticals Corporation, its affiliates, service providers, and agents ("Novartis"), for the purposes described above. I also give permission to NPAF to combine or aggregate any information collected from me with information NPAF may collect about me from other sources for the purpose of providing or administering program services.

I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law and applicable state law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization with respect to NPAF at any time in the future by calling 1-(800)-277-2254 or writing to P.O. Box 52029, Phoenix, AZ 85072-2029.

My refusal or future revocation will not affect the commencement or continuation of my treatment by my HCPs; however, if I revoke this authorization, I may no longer be able to participate in programs administered by NPAF. If I revoke this authorization, NPAF will stop using or sharing my information (except as necessary to end my participation in NPAF) but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that programs administered by NPAF may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

I agree to be contacted by NPAF by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the NPAF application for all purposes described in this Patient Authorization. I also agree to be contacted by NPAF and others on its behalf by telephone calls and text messages made by or using an autodialer or prerecorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys, and confirming that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided. I agree to notify NPAF promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand and agree that Personal Information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

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Patient Application

Please check one of the following: ☐ I am re-enrolling ☐ I am a new patient

⇨ SECTION 1: Patient Information

Patient's First Name: _____ Last Name _____
Date of Birth: MONTH _____/DAY _____/YEAR _____ Gender: _____
Reside in U.S. or Territory: ☐ Y ☐ N Email: _____
Household Size: _____ Cell #: _____ Home #: _____
Address: _____ Apt/Unit #: _____
City: _____ State: _____ Zip Code: _____

Caregiver (optional): First Name: _____ Last Name: _____
Telephone Number: _____ Relationship: _____
I have spoken to my caregiver and they agree to receive non-marketing calls from Novartis or NPAF, including through an autodialer or prerecorded voice, at the number provided, and I authorize NPAF to speak to the following person about my health condition and regarding the NPAF program.

⇨ SECTION 2: Insurance Information

Submit copies of the front and back of ALL insurance cards and write details of your insurance cards below:

Plan Type	Plan Name	ID #	Phone #
Medicare (Red/White/Blue Card)			
Medicare Part D/Advantage			
Medicaid/Tricare/VA/DoD			
Private Insurance			

If you have insurance through an employer - Employer Name: _____
☐ I have no prescription drug coverage.

⇨ SECTION 3: Income

Eligibility into the NPAF program requires that you provide your proof of income. You must send in a copy of the first 2 pages of your latest Federal tax return (e.g., 1040).

⇨ SECTION 4: Would You Like to Receive Refill Reminders?

☐ Yes, I would like to be able to request refills and get status updates about my prescription by phone or text. **By checking this box**, I agree to receive calls and texts at the phone number provided. I understand calls and texts may be autodialed or prerecorded and are not a condition of purchase or program participation. If I wish to participate via text, I will confirm when prompted to opt-in on texting.

SECTION 5: Patient Authorization and Certification

I confirm my information above is complete and accurate and that I have read and agree to the Patient Authorization on page 2.

PATIENT SIGNATURE: _____ **MONTH:** _____/**DAY**_____/**YEAR**_____
(REQUIRED) **(REQUIRED)**

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Prescriber Application

Reason for patient applying to NPAF: ☐ No Insurance Coverage ☐ Drug Not Covered ☐ Copay unaffordable for patient

SECTION 1: Prescriber Information

Prescriber First Name: _____ Last Name: _____ Phone Number: _____

Fax: _____ State License #: _____ NPI #: _____

Email address: _____ Office Contact Name: _____

Mailing address: _____ Suite#: _____

City: _____ State: _____ Zip Code: _____

SECTION 2: Patient History

Patient's Name: _____ Last Name: _____

Gender: _____ Date of Birth: MONTH _____/DAY _____/YEAR _____

List Other Medications: _____

List Other Health Conditions: _____

Allergies: ☐ Y ☐ N If yes list: _____ Organ Transplant date (If applicable): _____/_____/_____

SECTION 3: Medication(s) Requested

Medication Name #1: _____ Dosage Form: _____ Strength: _____

Medication Name #2: _____ Dosage Form: _____ Strength: _____

SECTION 4: Prescribing Instructions

A completed, legal, and valid prescription **must be faxed directly from the healthcare provider** with this enrollment form to avoid any delays in processing. **Please fax:1-(855)-817-2711**.

- We encourage prescriptions for 90-day supply with up to one year of refills.
- NOTE: All prescribers must comply with applicable state-specific prescription requirements. The filling pharmacy is located in Texas and thus requires advanced practitioners to provide the name of a supervising or collaborating physician.

SECTION 5: Prior Authorization Requirement

If the patient is insured and the insurance requires a Prior Authorization (PA), you must submit a copy of the PA outcome. When applicable, also submit a copy of PA Appeal outcome.

SECTION 6: Prescriber Certification and Signature

Health Care Provider Authorization

I certify that the above therapy is medically necessary and that this information is accurate to the best of my knowledge. I certify that I am the physician who has prescribed the drug identified above to the previously identified patient. For the purposes of transmitting this prescription, I authorize NPAF and its affiliates, business partners, and agents to forward, as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies.

I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Further, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that NPAF may revise, change, or terminate programs at any time. I have discussed NPAF with my patient, who has authorized me under HIPAA and state law to disclose their information to Novartis for the limited purpose of enrolling in NPAF. To complete this enrollment, Novartis may contact the patient by phone, text and/or email.

Novartis Patient Assistance Foundation, Inc. (NPAF) Health Care Provider Authorization

I have read and agree to the Health Care Provider Authorization and authorize the above prescription:

PRESCRIBER SIGNATURE: _____ MONTH_____/DAY_____/YEAR_____
(REQUIRED) **(REQUIRED)**

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080