NOVARTIS | PATIENT ASSISTANCE FOUNDATION, INC.

PATIENT APPLICATION

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

1 Patient Information

*= REQUIRED FIELDS

First Name* | Last Name* | Email

Date of Birth (MM/DD/YYYY)* | Sex for Clinical Use*: ☐ Male ☐ Female | Mobile Number* — *We'll keep you updated through non-marketing calls/texts.†*

Address (No PO Box)* | Home Number* — *We'll keep you updated through non-marketing calls/texts.†*

City* | State* | ZIP* | Household Size* | Reside in the U.S. or Territory*: ☐ Yes ☐ No

I give permission to disclose my personal health information to the following caregiver:

Caregiver Name | Relationship to Patient | Phone Number

2 Insurance Information

To prevent delays, please include copies (front and back) of **all** insurance card(s). This includes primary, secondary, and prescription insurance.

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

Employer Name (if you have insurance through an employer): _____

☐ I have no prescription drug coverage.

3 Income

Eligibility for the NPAF program requires that you provide your proof of income.
You must submit a copy of the first 2 pages of your most recent tax return (eg, 1040).*

4 Patient Authorization

I have read and agree to the Patient Authorization on page 2.

X _____ / / _____

Patient/Legal Guardian Signature* | **Date (MM/DD/YYYY)**

Complete the entire form and fax to NPAF at **1-855-817-2711** or mail to: **NPAF, PO Box 2529, Columbus, OH 43216**
An incomplete form will result in a processing delay or application denial.

Visit Website www.PAP.Novartis.com
Send Fax 1-855-817-2711
Questions? Call 1-800-277-2254
Mail to PO Box 2529 Columbus, OH 43216

Patient Authorization

I authorize my healthcare providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment and prescription details ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") and the Novartis Patient Assistance Foundation, Inc., and its service providers ("NPAF") so they can provide the following support services (the "Services"):

- Help coordinate insurance coverage for, access to, and receipt of my medication.
- Communicate with me about possible financial assistance, including Novartis Co-Pay or NPAF programs, and, if I am enrolled, administer my participation in those programs.
- Communicate with me about my medication and treatment, including reminders, health and lifestyle tips, and product and other related information. Communications may be customized based on Personal Information obtained from my Providers.
- Conduct quality assurance and other internal business activities and ask for feedback related to the Services or my treatment.

In delivering the Services, Novartis and NPAF may share my Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with information collected from other sources and use that information to administer the Services. My pharmacies or other healthcare providers may receive payment from Novartis or NPAF for providing certain Services, such as medication or refill reminders, based on my enrollment or participation. Once I authorize disclosure of my Personal Information, it may no longer be protected by federal health privacy law and applicable state laws.

I understand I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling 1-800-277-2254 or by writing to:

NPAF
PO Box 2529
Columbus, OH 43216

OR

Customer Interaction Center
Novartis Pharmaceuticals Corporation
One Health Plaza
East Hanover, NJ 07936-1080

This Authorization will expire 5 years after I sign it, or earlier if required by state law, unless I cancel it sooner. If I cancel it, I may no longer qualify for Services from Novartis or NPAF, but it will not impact my Provider's treatment or my insurance benefits. I also understand that if a Provider is disclosing my Personal Information to Novartis or NPAF on an authorized, ongoing basis, my cancellation will be effective with respect to that Provider as soon as they receive notice of my cancellation. Cancellation will not affect prior uses or disclosures.

†Novartis Patient Assistance Foundation, Inc (NPAF) may call and text you at the numbers provided for nonmarketing purposes (eg, to help you access and start on your medication). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 1-800-277-2254.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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PRESCRIBER APPLICATION

1 Prescriber Information

* = REQUIRED FIELDS

First Name* _____ Last Name* _____ Practice Name _____

Address* _____ Practice Phone Number _____

City* _____ State* _____ ZIP* _____ Office Contact Name _____ Office Contact Phone _____

Provider NPI Number* _____ Office Fax* _____

State License Number _____ Office Email _____

2 Patient Information

First Name* _____ Last Name* _____ ___/___/___ Date of Birth (MM/DD/YYYY)* Sex for Clinical Use*: ☐ Male ☐ Female

FDO Date (if applicable) _____

3 Prescription

Medication Brand Name	Strength	Directions	Quantity	Refills
	If an injectable: ☐ Pen ☐ Syringe ☐ Cartridge		☐ 90 days ☐ Other: _____	☐ 1 year ☐ Other: _____
	If an injectable: ☐ Pen ☐ Syringe ☐ Cartridge		☐ 90 days ☐ Other: _____	☐ 1 year ☐ Other: _____

4 Prior Authorization

If the patient is insured and the insurance requires a Prior Authorization (PA), you must submit a copy of the PA and/or Appeal outcome for the medication.

5 Provider Attestation

Prescriber must authorize these instructions by signing at the end of this section.

I certify that the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify that I am the provider who has prescribed the drug identified above to the patient named on this form. I certify that any medication received from Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") or the Novartis Patient Assistance Foundation, Inc. and its service providers ("NPAF"), will be used only for the patient named on this form and will not be offered for sale, trade, or barter, returned for credit, or submitted for reimbursement in any form. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Novartis and NPAF may revise, change, or terminate their respective programs at any time. 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 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, or email.

X _____ ___/___/___

Provider Signature* (Dispense as Written) **Date (MM/DD/YYYY)**

ATTN: Please follow your state's prescribing guidelines for electronic prescriptions.

Complete the entire form and fax to NPAF at **1-855-817-2711** or mail to: **NPAF, PO Box 2529, Columbus, OH 43216**
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