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

Thank you for your interest in the Novartis Patient Assistance Foundation, Inc. (NPAF)

Please visit **www.PAP.Novartis.com** for a complete list of medications and income requirements.

Eligibility Criteria – To be eligible, a patient must:

- Reside in the United States or a U.S. Territory
- Meet the income requirements
- Have limited or no prescription coverage

Instructions

To see if you are eligible, you will need to complete Patient Sections 1-5 on the Patient Application:

- **Patient Section 1:** Fill out your information completely and accurately. This will allow us to review your case and determine your eligibility for our program.
- **Patient Section 2:** If you have insurance, you will need to include a copy, of both the front and back, of all insurance cards (covering medical and prescription). If your insurance is provided by your employer, please provide a copy of the ***"Summary of Benefits"*** prepared by the Human Resources department of your employer. This will allow us to verify your benefit coverage.
- **Patient Section 3:** You will need to provide proof of your household's gross income. You can choose ONE of the following options to verify your proof of income:
  - To allow for quicker processing, we can perform an electronic income check. This will be done only to verify your income and will have NO effect on your credit score/rating. If you want this option, please note that you need to be 18 years or older. If you want to choose this option, please read and check the **Fair Credit Reporting Act (FCRA)** Consent on the Patient Application for this optional service.

  OR

  - You can include a copy of your financial documents, which include the following:
    - Most recent year's tax return
    - W-2 form
    - Three months of paycheck stubs
    - Social Security statement (1099)

- **Patient Section 4:** If you become enrolled, we can use our autodialer/automated system to remind you when your next refill order can be placed and we can text you eligibility and refill information. For this option, please read and check the **Telephone Consumer Protection Act (TCPA)** Consent if you want to allow us to contact you this way. This is optional and may be easier to help you manage your enrollment.
- **Patient Section 5:** We need you to read the Patient Authorization page to allow us to process your application, communicate with you and manage your enrollment. Please read, sign and date at the bottom of the Patient Application.

Lastly, work with your health care provider (HCP) to complete his/her sections of the application. If you have insurance and your policy requires a Prior Authorization, your HCP will need to obtain it and include it with their portion of the application.

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 Name: _____ Date of Birth: _____/_____/_____

Gender: ☐ M ☐ F Reside in U.S. or Territory: ☐ Y ☐ N Veteran: ☐ Y ☐ N Disabled: ☐ Y ☐ N

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip Code: _____

Cell #: _____ Email: _____

Home #: _____ Primary language spoken at home: _____

Annual Gross Income: $ _____ Total number of people in your household (including self): _____

Name of Authorized Person or Party: _____ Relationship: _____

By providing this information, you authorize NPAF to discuss your health condition and participation in the NPAF program with the authorized person or party named above.

SECTION 2: Insurance Information - Complete all that apply.

Provide copies of the front and back of ALL insurance cards.

☐ **UNINSURED**

☐ **Medicare Part A and/or B** ID #: _____

☐ **Medicare Part D or Advantage Plan** Ins. Company: _____

☐ **Medicaid State Program** State: _____

☐ **Prescription drug coverage** Ins. Company: _____

☐ **Coverage through an employer** Ins. Company: _____

Employer Name: _____

Provide a copy of the ***"Summary of Benefits"***, see information page for more detail.

SECTION 3: Fair Credit Reporting Act (FCRA) Consent

As described on the Instructions Page, you have the option to allow NPAF to perform an electronic income verification to process your application. Please check here if you wish to choose this option and not send in your income documents as noted on the Instructions Page.

☐ I understand that I am providing "written instructions" under the FCRA, authorizing NPAF and its vendor, on an ongoing basis as needed for the duration of my participation in programs administered by NPAF, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for programs administered by NPAF. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process.

SECTION 4: Telephone Consumer Protection Act (TCPA) Consent

As described on the Instructions Page, you may allow us to contact you using an automated dialing system, pre-recorded messages, or by text messages to help manage your enrollment and refills, once enrolled. If you wish to choose this option, please check the box below:

☐ I consent to receive marketing calls and texts from and on behalf of NPAF, made with an auto dialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Number of messages will vary based on your program selections. Message and data rates may apply.

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.

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____

(REQUIRED) **(REQUIRED)**

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Prescriber Application

SECTION 1: Prescriber Information

Prescriber Full Name: _____ Phone Number: _____ Fax: _____

Facility Name or Group Practice Name, if applicable: _____

Office Coordinator Name: _____ Prescriber's Office Address: _____

Suite #: _____ City: _____ State: _____ Zip Code: _____

DEA/State License #: _____ NPI #: _____

Email: _____

SECTION 2: Patient History

Patient's Name: _____ Date of Birth: _____/_____/_____ ☐ No known allergies

Allergies: _____ Current Medications: _____

Transplant date: _____/_____/_____ FDO: _____

SECTION 3: Prescription

Medication #1 Name: _____ Strength: _____ If an injectable, please specify: ☐ Pen ☐ Syringe ☐ Cartridge

Directions: _____

☐ 90 Days Supply ☐ Other: _____ Refill: ☐ 1 year ☐ Other: _____

ICD-10 (**REQUIRED**): _____

_____

Medication #2 Name: _____ Strength: _____ If an injectable, please specify: ☐ Pen ☐ Syringe ☐ Cartridge

Directions: _____

☐ 90 Days Supply ☐ Other: _____ Refill: ☐ 1 year ☐ Other: _____

ICD-10 (**REQUIRED**): _____

NOTE: Please be aware, if a Prior Authorization (PA) is required for the Novartis product(s) requested, you will need to provide that PA # and date of approval, or attach a copy of the denial letter. If this is a January renewal, you will need to process and forward a new PA. If we do not receive this information with the HCP portion of the application, there may be a delay in processing for your patient.

SECTION 4: 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.

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: _____ **DATE:** _____/_____/_____
(REQUIRED) **(REQUIRED)**

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Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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