www.PAP.Novartis.com
Phone: 1-800-277-2254 **Fax:** 1-(855)-817-2711
P.O. Box 2529 Columbus, OH 43216
Monday-Friday 8:00 a.m. to 8:00 p.m.

Novartis Patient Assistance Foundation, Inc. (NPAF)

RE: Request for Denial Reconsideration

Dear Patient:

Thank you for contacting the Novartis Patient Assistance Foundation (NPAF) to request reconsideration of your denial to the NPAF program.

Denials will only be reconsidered if one or more of the following apply:

- Change in income/employment status
- Change in insurance coverage for Novartis medication
- Correction to information provided in original enrollment
- Limited or no drug coverage for the Novartis medication

Note: Changes in personal expenses (other than your out-of-pocket obligation for the cost of your Novartis medication) are not cause for reconsideration.

Please review and complete the attached form, describing the changes in your situation, and submit along with any supporting documentation you may have available.

Please allow at least two weeks for review. We will reach out to you with the final outcome.

If you need assistance or have any questions, please call NPAF at 1-800-277-2254, Monday through Friday, 8:00 am to 8:00 pm ET.

Sincerely,
Novartis Patient Assistance Foundation, Inc.

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Novartis Patient Assistance Foundation, Inc.
Denial Reconsideration Application

Patient Name:

Patient ID:

Requested Novartis Medication:

Note: If you were denied for multiple Novartis medications, please list them here:

_____

1. Please check the box(es) below that apply to your situation
2. Describe your situation below
3. Attach copies of your updated income and/or insurance documents

I certify that it is difficult for me to afford my Novartis medication and I am requesting NPAF to reconsider the denial of my application for the following reason(s) (*select all that apply*)**:**

- ☐ I had a change in my income/employment status (you must attach updated annual household income (updated tax return or documents totaling all annual household income))
- ☐ I had a change in my insurance coverage
- ☐ I need to correct information in my enrollment application
- ☐ Limited or no drug coverage for the Novartis medication

Note: Changes in personal expenses (other than your out-of-pocket obligation for the cost of your Novartis medication) are not cause for reconsideration.

Please describe the change in income and/or change in insurance:

_____

_____

_____

_____

_____

_____

_____

I confirm that the information provided on the above form and in the attached documents are complete and accurate to the best of my knowledge.

_____

Patient Signature _____ Date _____

Novartis Patient Assistance Foundation, Inc., at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted.