

Enrollment Application for the Novartis Patient Assistance Foundation, Inc.

Information

P.O. Box 52029, Phoenix, AZ 85072-2029 | Phone: 1-800-277-2254 | Fax: 1-855-817-2711

Dear Patient and Health Care Professional (HCP):

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

To be eligible, a patient must:

- Be a U.S. resident
- Meet the income requirements
- Have limited or no prescription coverage

The following products are available:

AFINITOR® (everolimus) tablets
AFINITOR DISPERZ™ (everolimus tablets for oral suspension)
ARZERRA® (ofatumumab)
AZOPT® (brinzolamide suspension)
CIPRODEX** (ciprofloxacin and dexamethasone)
COARTEM® (artemether and lumefantrine)
COSENTYX® (secukinumab)
DUREZOL® (difluprednate emulsion)
ENTRESTO® (sacubitril/valsartan)
EXJADE® (deferasirox)
EXTAVIA® (Interferon beta-1b)
GILENYA® (fingolimod)
GLATOPA® (glatiramer acetate injection)
GLEEVEC® (imatinib mesylate) tablets
HYCAMTIN® (topotecan hydrochloride) for injection
HYCAMTIN® (topotecan) capsules
ILARIS® (canakinumab)
ILEVRO® (nepafenac suspension)
JADENU® (deferasirox) tablets
JADENU® Sprinkle (deferasirox) granules
KISQALI® (ribociclib) tablets
KISQALI® FEMARA® Co-Pack
MAYZENT® (siponimod)
MEKINIST® (trametinib) tablets
MYFORTIC® (mycophenolic acid)
NEORAL® (cyclosporine)
OMNITROPE® (somatropin [rDNA origin] for injection)
PATADAY® (olopatadine hydrochloride solution)
PAZEO® (olopatadine hydrochloride solution)
PROMACTA® (eltrombopag) tablets
RECLAST® (zoledronic acid)
SANDIMMUNE® (cyclosporine)
SANDOSTATIN® LAR DEPOT (octreotide acetate for injectable suspension)
SIGNIFOR® (pasireotide) injection
SIGNIFOR® LAR (pasireotide) for injectable suspension
SIMBRINZA® (brinzolamide/brimonidine tartrate suspension)
TAFINLAR® (dabrafenib) capsules
TASIGNA® (nilotinib) capsules
TEGRETOL® (carbamazepine USP)
TEGRETOL®-XR (carbamazepine extended-release tabs)
TRAVATAN Z® (travoprost solution)
TRILEPTAL® (oxcarbazepine)
TYKERB® (lapatinib) tablets
VIGAMOX® (moxifloxacin hydrochloride solution)
VOTRIENT® (pazopanib) tablets
ZORTRESS® (everolimus)
ZYKADIA® (ceritinib) capsules

*Additional products may be available. Please check the NPAF website at www.pap.novartis.com for the complete product listing.

Patient Section A

P.O. Box 52029, Phoenix, AZ 85072-2029 | Phone: 1-800-277-2254 | Fax: 1-855-817-2711

Patient's Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Cell #: _____ **Home #:** _____
Best Number to Call: _____
Email: _____

US Resident: Y N **Gender:** M F **Veteran:** Y N
Disabled: Y N (Status as deemed by social security)

Date of Birth: _____ / _____ / _____

Medication(s) 1: _____

Medication(s) 2: _____

Caregiver/Family Member: _____

Address: _____

City: _____ **State:** _____

Zip: _____ **Phone:** _____

Financial Documentation Options for verifying income to determine NPAF eligibility:

1. Check the Fair Credit Reporting Act consent at the bottom of this page to allow for electronic income verification OR
2. Provide financial documentation as indicated below:
 Attach a copy of your household's most recent year's tax returns, 3 months of paycheck stubs OR bank statements OR unemployment checks. **Do not send original documents with your form.**

Total # of people in the home (including self, please add all those who are living with you)
 1 2 3 4 5 6 or more
of Children: _____ **# of Adults:** _____

List all sources of Gross Monthly Income:

Salary/Wages (All Sources): \$ _____
 Pension/Retirement: + \$ _____
 Social Security: + \$ _____
 Disability: + \$ _____
 Unemployment Benefits: + \$ _____
 Alimony/Child Support: + \$ _____
 Total Gross Monthly Household Income = \$ _____

PATIENT INSURANCE: Please include a copy of the front and back of your prescription and insurance card (REQUIRED)

	Coverage	Identification No.	Phone Number	Effective Date
Medicare Part B	<input type="checkbox"/> Y <input type="checkbox"/> N		() ____ - ____	
Medicare Part D	<input type="checkbox"/> Y <input type="checkbox"/> N		() ____ - ____	
Medicaid	<input type="checkbox"/> Y <input type="checkbox"/> N		() ____ - ____	
State elderly drug assistance	<input type="checkbox"/> Y <input type="checkbox"/> N		() ____ - ____	
State children health insurance	<input type="checkbox"/> Y <input type="checkbox"/> N		() ____ - ____	
Veterans assistance	<input type="checkbox"/> Y <input type="checkbox"/> N		() ____ - ____	
Medical/Prescription Coverage	<input type="checkbox"/> Y <input type="checkbox"/> N		() ____ - ____	
Other - If YES, indicate reason for application, i.e., drug not covered	<input type="checkbox"/> Y <input type="checkbox"/> N		() ____ - ____	
Did Medicare pay for your transplant?	<input type="checkbox"/> Y <input type="checkbox"/> N		____/____/____ DATE OF TRANSPLANT	

NOVARTIS PATIENT ASSISTANCE FOUNDATION, INC. (NPAF) Patient Consent

SIGNATURE REQUIRED FOR PATIENTS APPLYING FOR Patient Assistance Program (PAP) – MANDATORY FOR PROCESSING. **I have read and agree to the Patient Assistance Program (PAP) Patient Consent - Section B on page 4 of this document.** If my income or health coverage changes, I will call NPAF at 1-800-277-2254.

- I have read and agree to the TCPA Consent on page 5 (optional)
- I have read and agree to the FCRA Authorization on page 5 (optional)

PRINT PATIENT NAME _____

PATIENT SIGNATURE _____

DATE (REQUIRED) _____

Health Care Professional Section A

P.O. Box 52029, Phoenix, AZ 85072-2029 | Phone: 1-800-277-2254 | Fax: 1-855-817-2711

HEALTH CARE PROFESSIONAL (HCP) INFORMATION: To be completed by the HCP.

HCP Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax (for providing updates): _____

DEA/State License #: _____ NPI #: _____

Patient Coordinator/Nurse Advocate: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT PRESCRIPTION

ICD-10 (REQUIRED): _____

Patient's Full Name: _____ **DOB:** ____ / ____ / ____

Medication #1: _____ **Strength:** _____ **Qty/Days Supply:** _____

Oral Pen Syringe Cartridge OS OD OU

Directions: _____ Refills: 1 YR or: _____

Medication #2: _____ **Strength:** _____ **Qty/Days Supply:** _____

Oral Pen Syringe Cartridge OS OD OU

Directions: _____ Refills: 1 YR or: _____

Please list patient's allergies: No known Or _____

List or attach other current medications prescribed: _____

REQUIRED SIGNATURE (DISPENSE AS WRITTEN):

DATE (REQUIRED)

***Note: If required by your state (ie., NY & DE), please fax an original Prescription blank.**

NOVARTIS PATIENT ASSISTANCE FOUNDATION, INC (NPAF) Health Care Professional Authorization
SIGNATURE REQUIRED for PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING
I have read and agree to the Physician Authorization - Section B on page 5 of this document.

PRINT HCP NAME

HCP SIGNATURE

DATE (REQUIRED)



Patient Consent - Section B

Please read, sign and date on page 2, Patient Section A.

I give permission for my health care providers (HCPs), pharmacies, health insurer(s), third party contractors, and service providers 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 those programs if I choose to apply and I am eligible, send me information about programs that might help me pay for my medicines, and to coordinate and share my Personal Information with my health care providers, other programs that might help me pay for medicines, government agencies, and insurance companies for purposes of providing or facilitating this assistance.

I give permission to NPAF to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers 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 and state privacy 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.

My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctors; 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 automatic telephone dialing system or pre-recorded 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. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided, and 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 that NPAF does not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

Patient Consent - Section B (Continued)

Telephone Consumer Protection Act (TCPA) Consent

I consent to receive marketing and non-marketing calls and texts from and on behalf of Novartis Pharmaceuticals Corporation, made with an autodialer 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.

Fair Credit Reporting Act (FCRA) Authorization

I understand that I am providing “written instructions” authorizing NPAF and its vendor, under the FCRA, 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.

Health Care Professional Authorization - Section B

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.

Patient Checklist Section

To prevent processing delays, please review your application for accuracy and completeness.

- Complete all questions and sign and date Patient Section A.
- Select method for documenting income: Read the Fair Credit Reporting Act Consent on page 5 and check the consent box on page 2 to provide consent for electronic income verification OR attach copies of required income and insurance documentation.
- Discuss PAP enrollment and submission of your application with your HCP.



If you have checked all of the boxes above, you are ready to submit the form!

Mail or Fax Patient Section A of the form with appropriate documentation to:

Fax: 1-855-817-2711

Novartis Patient Assistance Foundation, Inc., P.O. Box 52029, Phoenix, AZ 85072-2029

If you have any questions, please call a Novartis Patient Assistance Foundation, Inc. representative at **1-800-277-2254**, Monday through Friday, 8:00 am to 8:00 pm EST.

Health Care Professional Checklist Section

To prevent processing delays, please review your application for accuracy and completeness.

- Fill out the Health Care Professional Section A.
- Sign and Date the Rx Section on page 3.
- Sign and Date the Health Care Professional Authorization - Section A on page 3.



*If you have checked all of the boxes above, you are ready to submit the form!
If available, please provide any Prior Authorization denial documentation.*

Fax HCP Section A of the form with appropriate documentation to:

Fax: 1-855-817-2711

If you have any questions, please call a Novartis Patient Assistance Foundation, Inc. representative at **1-800-277-2254**, Monday through Friday, 8:00 am to 8:00 pm EST.