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)
- ARRANON® (nelarabine)
- ARZERRA® (ofatumumab)
- AZOPT® (brinzolamide suspension)
- COARTEM® (artemether and lumefantrine)
- COSENTYX® (secukinumab)
- DUREZOL® (difluprednate emulsion)
- ENTRESTO® (sacubitril/valsartan)
- EXJADE® (deferasirox)
- EXTAVIA® (Interferon beta-1b)
- FARYDAK® (panobinostat) capsules
- FOCALIN® XR (dexameth/phenidate hydrochloride)
- GILENYA® (fingolimod)
- GLATOPA® (gam奇幻er acetate injection)
- GLEEVEC® (imatinib mesylate) tablets
- HYCAMTIN® (topotecan hydrochloride) for injection
- HYCAMTIN® (topotecan) capsules
- ILARIS® (canakinumab)
- ILEVRO® (napafenac suspension)
- JADENU® (deferasirox) tablets
- KISQALI® (ribociclib) tablets
- LEVOLEUCOVORIN injection
- MEKINIST® (trametinib) tablets
- MYFORTIC® (mycophenolic acid)
- NEORAL® (cyclosporine)

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

Revised March 2017    10482-0317
# Patient Section A

**Patient's Name:** __________________________________________________

**Address:** _________________________________________________________

**City:** ______________________  **State:** ______

**Zip:** __________  **Phone:** ______________________

**Cell Phone:** ______________________________________________________

**US Resident:** ☐ Y  ☐ N  **Gender:** ☐ M  ☐ F  **Veteran:** ☐ Y  ☐ N

**Disabled:** ☐ Y  ☐ N (Status as deemed by social security)

**Social Security # (REQUIRED):** ______________________________  
**or**  
**Green Card ID #:** _____________________________________________

**Date of Birth:** ______ / ______ / ______

**Medication(s) 1:** _____________________________________________

**Medication(s) 2:** _____________________________________________

**Caregiver/Family Member:** ______________________________________

**Address:** _________________________________________________________

**City:** ______________________  **State:** ______

**Zip:** __________  **Phone:** ______________________

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**Financial Information:** 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 = $ __________________**

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## PATIENT INSURANCE

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

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Identification No.</th>
<th>Phone Number</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part B</td>
<td>☐ Y  ☐ N</td>
<td>(<em><strong><strong>)</strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>☐ Y  ☐ N</td>
<td>(<em><strong><strong>)</strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>☐ Y  ☐ N</td>
<td>(<em><strong><strong>)</strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>State elderly drug assistance</td>
<td>☐ Y  ☐ N</td>
<td>(<em><strong><strong>)</strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>State children health insurance</td>
<td>☐ Y  ☐ N</td>
<td>(<em><strong><strong>)</strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>Veterans assistance</td>
<td>☐ Y  ☐ N</td>
<td>(<em><strong><strong>)</strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>Medical/Prescription Coverage</td>
<td>☐ Y  ☐ N</td>
<td>(<em><strong><strong>)</strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>Other - If YES, indicate reason for application, i.e., drug not covered</td>
<td>☐ Y  ☐ N</td>
<td>(<em><strong><strong>)</strong></strong></em></td>
<td></td>
</tr>
<tr>
<td>Did Medicare pay for your transplant?</td>
<td>☐ Y  ☐ N</td>
<td>(<em><strong><strong>)</strong></strong></em></td>
<td>DATE OF TRANSPLANT</td>
</tr>
</tbody>
</table>

---

**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.

**PRINT PATIENT NAME**

**PATIENT SIGNATURE**

**DATE (REQUIRED)**

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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: __________________________
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 4 of this document.

PRINT PATIENT NAME

HCP SIGNATURE
DATE (REQUIRED)
Patient Consent - Section B

Please read, sign and date below. Missing signature or date may cause a delay in processing.

I give permission for my doctor(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition and health ("Health Information") to the Novartis Patient Assistance Foundation, Inc. (the "Foundation") so that the Foundation can decide if I am eligible for the Novartis Patient Assistance Program ("PAP"); operate the PAP and the Foundation; send me information about PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; ask me for financial, insurance and/or medical information and share my information as required or permitted by law. I give permission to the Foundation to use information on this form and any other information I give to the Foundation for these same reasons. I also give the Foundation permission to share my Health Information and other information with people and companies that work with the Foundation; government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my doctor(s) and other people, or institutions who are involved in my healthcare, such as pharmacies and hospitals; other organizations that might help me pay for my medication. I promise that any information, including financial and insurance information that I provide to the Foundation are complete and true and unless I have said something different on this form, I have no drug insurance coverage, which includes Medicaid, Medicare or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call the PAP at 1-800-277-2254. I know that the Foundation may change or end the PAP at any time. I know that if I do not sign this form, I will not be able to participate in the PAP, but this will not affect my ability to get medical care, seek payment for this care or affect my enrollment or eligibility for insurance. I know that I can cancel this permission at any time by calling the PAP at 1-800-277-2254. If I do, then I will not be able to stay in the PAP. I understand I have the right to receive a copy of this form.

Health Care Professional Authorization - Section B

Read, sign and date HCP authorization. Missing signature or date may cause a delay in processing.

My signature below certifies that the person listed above is my patient for whom I have prescribed the drug identified above. For the purposes of transmitting this prescription, I authorize Novartis Pharmaceuticals Corporation, 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 a dispensing pharmacy chosen by the above-named patient. I certify that any medications received from Novartis (as defined above) in connection with this application will be used only for the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. I acknowledge that I have assisted the patient in enrolling in the Novartis PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort. I also agree that Novartis has the right to contact the patient directly to confirm receipt of medications, and I understand that Novartis may revise, change, or terminate this program 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.
☐ Attach copies of all 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, 9:00 am to 6:00 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 B on page 4.

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, 9:00 am to 6:00 pm EST.