NOVARTIS

Information

# Enrollment Application for the Novartis Patient Assistance Foundation, Inc.

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

Dear Patient and Health Care Professional:

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

To be eligible for the Novartis Patient Assistance Foundation, Inc. patients must:

- Be a U.S. resident
- Meet the income requirements ***and***
- Have no private or public prescription coverage

The following products are available:

AFINITOR® (everolimus) Tablets for Oral Administration
AFINITOR DISPERZ™ (everolimus) Tablets for Oral Suspension
ARRANON® (nelarabine)
ARCAPTA™ NEOHALER™ (indacaterol inhalation powder)
ARZERRA® (ofatumumab)
COARTEM® (artemether and lumefantrine)
COSENTYX™ (secukinumab)
ENTRESTO™ (sacubitril/valsartan)
EXJADE® (deferasirox)
EXTAVIA® (Interferon beta-1b)
FARYDAK® (panobinostat) Capsules
FOCALIN® XR (dexmethylphenidate hydrochloride)
GILENYA™ (fingolimod)
GLATOPA™ (glatiramer acetate injection)
GLEEVEC® (imatinib mesylate)
HECORIA™ (tacrolimus)
HYCAMTIN® (topotecan hydrochloride) for Injection
HYCAMTIN® (topotecan) capsules
ILARIS® (canakinumab)
JADENU™ (deferasirox) Tablets
LAMISIL® Oral Granules (terbinafine hydrochloride)
LEVOLEUCOVORIN Injection
MEKINIST® (trametinib)
MYFORTIC® (mycophenolic acid)
NEORAL® (cyclosporine)
ODOMZO® (sonidegib)
OMNITROPE® (somatropin [rDNA origin] for injection)
PROMACTA® (eltrombopag)
RECLAST® (zoledronic acid)
SANDIMMUNE® (cyclosporine)
SANDOSTATIN LAR® Depot (octreotide acetate)
SIGNIFOR® (Pasireotide)
SIGNIFOR® LAR (Pasireotide) Injection
TAFINLAR® (dabrafenib)
TASIGNA® (nilotinib)
TEGRETOL® (carbamazepine USP)
TEGRETOL®-XR (carbamazepine extended-release tabs)
TEKTURNA® (aliskiren)
TEKTURNA HCT® (aliskiren and hydrochlorothiazide)
TOBI® (tobramycin inhalation solution USP)
TOBI®Podhaler™ (tobramycin inhalation powder)
TRILEPTAL® (oxcarbazepine)
TYKERB® (lapatinib)
TYZEKA® (telbivudine)
VOTRIENT® (pazopanib)
ZOMETA® (zoledronic acid)
ZORTRESS® (everolimus)
ZYKADIA™ (ceritinib)

**What to do:**

Step 1 – Complete and sign Patient Section (page 2)
Step 2 – Attach copies of all required financial documentation
Step 3 – Your Doctor completes and signs Prescription Section (page 3)
Step 4 – Mail or fax form with documentation

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**Patient Section**

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**Patient's Name**: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: _____

Cell Phone: _____

Email: _____

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

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

Social Security/ID No: _____

Date of Birth: _____ Product: _____

**Patient Advocate Name**: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: _____

Email: _____

**FINANCIAL INFORMATION:** Attach a copy of your household's most recent year tax returns (1040, 1040EZ, 1099, etc.)

**Do not send original documents with your application.**

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 INFORMATION: Please include a copy of the front and back of your Prescription Card and Insurance Card**

| | Medical Coverage | Identification No. | Phone Number | Effective Date |
|---|---|---|---|---|
| Medicare Part A | ☐ Y ☐ N | | (_____) _____-_____ | |
| Medicare Part B | ☐ Y ☐ N | | (_____) _____-_____ | |
| Medicare Part D | ☐ Y ☐ N | | (_____) _____-_____ | |
| Medicaid | ☐ Y ☐ N | | (_____) _____-_____ | |
| State Elderly Drug Assistance | ☐ Y ☐ N | | (_____) _____-_____ | |
| State Children Health Insurance | ☐ Y ☐ N | | (_____) _____-_____ | |
| Veterans Assistance | ☐ Y ☐ N | | (_____) _____-_____ | |
| Private Insurance | ☐ Y ☐ N | | (_____) _____-_____ | |
| Other | ☐ Y ☐ N | | (_____) _____-_____ | |

## Read & Sign Patient Authorization

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 Application 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 in this application, 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.

**Patient or Legal Guardian Signature:** _____ **Date:** _____

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**Prescription Section**

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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: _____

Email: _____

DEA/State License # : _____

NPI #: _____

**Advocate's Name:** _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

Email: _____

**Patient's Full Name**: _____

Patient's Date of Birth: _____

Please list patient's allergies: ☐ No known

_____

Please list any other medications the patient is currently taking: ☐ None

_____

Product: _____

Strength: _____ Quantity: _____

Directions: _____

Refills: One year or: _____ Date of transplant: _____ (if applicable)

**Physician Signature**:

☐ _____ _____
Substitutions permitted Date

☐ _____
Dispensed as written

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

## Read & Sign HCP Authorization

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. Finally, to the best of my knowledge, the patient listed above meets Novartis' eligibility criteria for the PAP.

**Prescriber Signature:** _____ **Date:** _____

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Checklist

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## *Did you:*

- ☐ Fill out the Patient Section?
- ☐ Sign the bottom of the Patient Section?
- ☐ Include a copy of your financial information?
- ☐ Have the doctor fill out the Prescription Section?
- ☐ Have the doctor sign the prescription and form?

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

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Follow these steps to complete your application process:

1. **Mail pages 2 and 3 of the Application with Financial Documentation to:**

   NOVARTIS PATIENT ASSISTANCE FOUNDATION, INC.
   P.O. Box 52029,
   Phoenix, AZ 85072-2029

## OR

2. **Fax pages 2 and 3 of the Application with a Health Care Professional Fax Cover Sheet and Financial Documentation to:**

   **Fax: 1-855-817-2711**

   - If the application is faxed, it must be sent from the Health Care Professional's office.

We will review and process your application once we receive the completed application with supporting financial documentation. You will receive a letter about your status soon.

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.