HCP | PANO Service Request Form

For more information, please call 1-800-282-7630 from 8:00 AM to 8:00 PM ET, Monday through Friday.

The PANO Service Request Form is used to assess patient eligibility for Novartis Oncology programs including financial assistance and free trial offers. To complete a single request, both the HCP and patient must submit information via 2 separate forms. Fill out the HCP form and alert your patient to complete the patient form. The HCP and patient submissions will be matched after both parts are submitted.

Fax Number: 1-888-891-4924

***Required Fields**

Patient Information

Patient First Name*	Last Name*	Date of Birth*	Email	
Phone Number	Street Address	City	State	Zip Code*

Insurance Information

Prescription Insurance Name	Member ID	Rx Group #	Rx BIN #	Pharmacy Services Phone (see back of card)
Primary Medical Insurance Name*	Primary Policy Holder First Name	Primary Policy Holder Last Name		
Primary Policy Holder Date of Birth*	Primary Medical Insurance Phone #*	Policy ID*	Group #	

Preferred Choice for Benefits Verification ☑ Medical Insurance ☐ Prescription Insurance

Please include a copy of the front and back of the patient's prescription insurance card(s) and medical insurance card(s)

Physician Information

First Name*	Last Name*	Practice/ Institution Name	
Office Contact Name*	Office Contact Phone (and extension)*	Office Contact Fax Number*	Office Contact Email
Street Address*	City*	State*	Zip Code*
Tax ID #	NPI #*	Medicaid Provider ID #	

Prescription Information

Product* AFINITOR® (everolimus) tablets

Medication Strength* ○ 2.5 mg tablet ○ 5 mg tablet ○ 7.5 mg tablet ○ 10 mg tablet

How many tablets*	How many times per day*	Quantity*	# of days supply*	Refills Authorized*
Primary ICD-10-CM Code*	Secondary ICD-10-CM Code			
Is your patient new to this therapy in the last 2 months?* ○ Yes ○ No	Prior Treatment* (if any)			

Prescriber signature and details are required for the Novartis Patient Assistance Foundation, Inc. (NPAF) on page 2.

Novartis Free Trial Program (14-Day Free Trial)

Free Trial ☐ Yes

Eligible patients receive a free 1-time supply of the prescribed drug for an FDA-approved indication (per prescribed strength) without regard to purchase of their prescribed drug or any other product. Novartis reserves the right to rescind, revoke, or amend the program without notice. The supply can be shipped directly to patients so they can start treatment immediately.

If Yes, prescriber signature and details are required for the "Novartis Free Trial Program" on page 2.

NOTE: If your state requires, please submit a state-approved prescription with this completed form.
NOTE: Depending on selected programs, additional prescriptions may be required.
Visit www.hcp.novartis.com to access the full Prescribing Information for each product and/or the HCP PANO Service Request Form.

Physician Authorization

My signature certifies that I am the physician who has prescribed the selected drug to the patient identified.

I certify that I have made an independent judgment that this therapy is medically necessary, and that I have provided the patient with materials that describe the Novartis Oncology Service Request Form for Patient Support.

Finally, for the purposes of transmitting this prescription, I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, third-party contractors, agents, and NPAF, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by the patient named.

NPAF CONSENT FOR PHYSICIAN (MANDATORY FOR PATIENTS ENROLLING IN NPAF)

I certify that this 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.

#1 A physician's signature and date are required to process this document.

Physician Signature Required

Physician Authorization – Mandatory for Processing
I have read and agree to the **Physician Authorization**.

X _____

Prescriber Signature (no stamps)

_____

Date* (Required)

#2 A physician's signature and date are required to process this prescription.

Patient Name: _____

Address: _____

Date of Birth: _____ Date: _____

℞

AFINITOR® (everolimus) tablets

- ○ 2.5 mg tablet strength
- ○ 5 mg tablet strength
- ○ 7.5 mg tablet strength
- ○ 10 mg tablet strength

Sig: Take _____ tablets _____ times a day

Quantity: _____ Refills: _____

Prescription Information Signature – Required for All Products
I certify that I am the health care professional who has prescribed the above therapy to the previously identified patient, that I have made an independent judgment that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

Prescriber Name: _____

X _____ _____

Prescriber Signature (no stamps) Date* (Required)

○ Dispense as written ○ May substitute

This Rx is required for NPAF

NOTE: A 1-year supply of refills will prevent us from having to contact you later for refills.

#3 A physician's signature and date are required to process this prescription.

Patient Name: _____

Address: _____

Date of Birth: _____ Date: _____

℞

AFINITOR® (everolimus) tablets

- ○ 2.5 mg tablet strength
- ○ 5 mg tablet strength
- ○ 7.5 mg tablet strength
- ○ 10 mg tablet strength

Sig: Take _____ tablets _____ times a day

Quantity: 14-Day Supply Refills: No Refills

Prescription Information Signature – Required for All Products
I certify that I am the health care professional who has prescribed the above therapy to the previously identified patient, that I have made an independent judgment that the above therapy is medically necessary, within the FDA-approved prescribing information, and that the information provided is accurate to the best of my knowledge. I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

Prescriber Name: _____

X _____ _____

Prescriber Signature (no stamps) Date* (Required)

○ Dispense as written ○ May substitute

This Rx is for the Novartis Free Trial Program, if selected on page 1.

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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