Novartis Patient Assistance Foundation, Inc.

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)
ARRANON® (nelarabine)
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)
FARYDAK® (panobinostat) capsules
FOCALIN® XR (dexmethylphenidate hydrochloride)
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
LEVOLEUCOVORIN injection
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)
TOBI® (tobramycin inhalation solution USP)
TOBI® Podhaler® (tobramycin inhalation powder)
TRAVATAN Z® (travoprost solution)
TRILEPTAL® (oxcarbazepine)
TYKERB® (lapatinib) tablets
VIGAMOX® (moxifloxacin hydrochloride solution)
VOTRIENT® (pazopanib) tablets
ZOMETA® (zoledronic acid) for injection
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.

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Revised July 2017 337554-0717

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: _____ 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: _____

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 = $ _____

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	☐ 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		(____) _____-_____	
Medical/Prescription Coverage	☐ Y ☐ N		(____) _____-_____	
Other - If YES, indicate reason for application, i.e., drug not covered	☐ Y ☐ N		(____) _____-_____	
Did Medicare pay for your transplant?	☐ Y ☐ 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.**

_____

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: _____

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 HCP NAME

_____ _____

HCP SIGNATURE **DATE (REQUIRED)**

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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 Authorixation - 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.

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