

PATIENT APPLICATION

	Please check one of the following boxes*:								
1 Patient Informa	ation					*=REQUIRED FIELDS			
First Name*		Last Name*		Email					
/ Sex for Clinical Use*:			Male Female	e Female					
Date of Birth (MM/DI	D/YYYY)*				Mobile Number★—We'll keep you updated through non-marketing calls/texts. [†]				
Address (No PO Box)*				Home Number*—We'll keep you updated through non-marketing calls/texts.					
					_ Reside in the U.S. or Te	rritory*: Yes No			
City*		State*	ZIP*	Household Size*					
I give permission to di	sclose my personal	health information to the	following caregiver:						
Caregiver Name		Relation		ip to Patient	Phone Nun	Phone Number			
			surance card(s). This		secondary, and prescription				
Plan Type		Plan Name		ID#	Phone	Phone#			
Medicare (Red/White/Blue Card)									
Medicare Part D/Advantage									
Medicare Suppler	mental/Other								
Medicaid/Tricare/VA/DoD									
Private Insurance									
Employer Name (if yo	ou have insurance the								
		that you provide your pr es of your most recent t		r					
4 Patient Author I have read and agr		thorization on page 2.				/ /			
Patient/Legal Gua	ardian Signature*				D	ate (MM/DD/YYYY)			

Complete the entire form and fax to NPAF at 1-855-817-2711 or mail to: NPAF, PO Box 2529, Columbus, OH 43216

An incomplete form will result in a processing delay or application denial.







Mail to PO Box 2529 Columbus, OH 43216

Page 1 of 2 8/23

Patient Authorization

I authorize my healthcare providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment and prescription details ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") and the Novartis Patient Assistance Foundation, Inc., and its service providers ("NPAF") so they can provide the following support services (the "Services"):

- Help coordinate insurance coverage for, access to, and receipt of my medication.
- Communicate with me about possible financial assistance, including Novartis Co-Pay or NPAF programs, and, if I am enrolled, administer my participation in those programs.
- Communicate with me about my medication and treatment, including reminders, health and lifestyle tips, and product and other related information. Communications may be customized based on Personal Information obtained from my Providers.
- Conduct quality assurance and other internal business activities and ask for feedback related to the Services or my treatment.

In delivering the Services, Novartis and NPAF may share my Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with information collected from other sources and use that information to administer the Services. My pharmacies or other healthcare providers may receive payment from Novartis or NPAF for providing certain Services, such as medication or refill reminders, based on my enrollment or participation. Once I authorize disclosure of my Personal Information, it may no longer be protected by federal health privacy law and applicable state laws.

I understand I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling 1-800-277-2254 or by writing to:

NPAF Customer Interaction Center

PO Box 2529 OR Novartis Pharmaceuticals Corporation

Columbus, OH 43216 One Health Plaza

East Hanover, NJ 07936-1080

This Authorization will expire 5 years after I sign it, or earlier if required by state law, unless I cancel it sooner. If I cancel it, I may no longer qualify for Services from Novartis or NPAF, but it will not impact my Provider's treatment or my insurance benefits. I also understand that if a Provider is disclosing my Personal Information to Novartis or NPAF on an authorized, ongoing basis, my cancellation will be effective with respect to that Provider as soon as they receive notice of my cancellation. Cancellation will not affect prior uses or disclosures.

†Novartis Patient Assistance Foundation, Inc (NPAF) may call and text you at the numbers provided for nonmarketing purposes (eg, to help you access and start on your medication). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 1-800-277-2254.

Page 2 of 2



8/23



PRESCRIBER APPLICATION

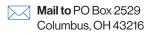
1 Prescriber Information	on						EQUIRED FIELDS		
First Name*	me* Last Name*			Practice Name					
Address*	Practice Phone Number								
City*	State*	ZIP*	Office Contact Name		Office C	Office Contact Phone			
Provider NPI Number*	Office Fax*								
State License Number			Office Email						
2 Patient Information									
First Name*	Last Name*		Date of Birth (MM/DD/YYYY)*		_ Sex for (ex for Clinical Use*:			
FDO Date (if applicable)			-						
3 Prescription									
Medication Brand Name	Strength	Directions		Quantity		Refills			
	If an injectable: ☐Pen ☐Syringe ☐Cartridge			90 days		1year Other:			
	If an injectable: ☐Pen ☐Syringe ☐Cartridge			90 days		1year Other:			
4 Prior Authorization If the patient is insured and t	he insurance requires a Prior Au	thorization (PA), you m	nust submit a copv	of the PA and/or Ar	opeal outo	come for the	medication.		
5 Provider Attestation Prescriber must authorize to I certify that the above there prescribed the drug identificits affiliates and service provider the patient named on this acknowledge that NPAF is change, or terminate their repartners, and agents to forw dispensing pharmacies. I have discussed NPAF will limited purpose of enrolling the provider of the patient o	hese instructions by signing at tapy is medically necessary and the dabove to the patient named of viders ("Novartis") or the Novart is form and will not be offered for exclusively for purposes of patients are any time ward, as my agent for these limit the my patient, who has authoring in NPAF. To complete this expective programs as a support the second in the sec	the end of this section this information is acc on this form. I certify th is Patient Assistance r sale, trade, or barter, ent care and not for re . For the purposes of the purposes, this presented me under HIPA	urate to the best on the best on the best of the best	of my knowledge. I on received from Nowledge it, or submitted for a sort. I understand rescription, I authorically, by facsimile, on the control of the cont	certify tha vartis Pha ders ("NP, reimburse that Nova rize NPAF or by mail	at I am the pro armaceutical AF"), will be to ement in any artis and NPA and its affilia to the appro on to Novart email.	ovider who has a Corporation, used only form. I AF may revise, ates, business opriate		
Provider Signature* (Dispense as Written)						Date (MM/DD/YYYY)			
ATTN: Please follow your st	tate's prescribing guidelines for	electronic prescription	ons.						

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Visit Website www.PAP.Novartis.com







8/23