NOVARTIS ONCOLOGY SERVICE REQUEST FORM FOR PATIENT SUPPORT

For more information, please call **1-800-282-7630 from 9:00 AM to 8:00 PM ET, Monday through Friday.**

Please complete the Fax Cover Sheet and Service Request Form, and fax to the number specified below.

Dear Health Care Professional:

The Novartis Oncology Service Request Form helps assess patient eligibility for Novartis programs. It is therefore essential to complete the enclosed enrollment form in full, including all required signatures by you and your patient. Without a fully completed form, support may be delayed while we obtain any missing information.

To: Patient Assistance Now Oncology (PANO)	Fax Number: 1-888-891-4924

Follow the steps below to complete the Service Request Form, and please check the completed sections

☐ Patient Information (Section 1)
Complete with all relevant information. Be sure the patient signs the **Patient Authorization**.

☐ Novartis Patient Assistance Foundation (NPAF) (Section 2)
This section only needs to be completed if applying for the NPAF. Novartis is committed to providing access to Novartis medications for those most in need. If a patient is experiencing financial hardship and has limited or no prescription coverage, he or she may be eligible to receive Novartis medications free. Please review the Financial Documentation Options to determine how the patient would like us to verify income.

☐ Insurance Information (Section 3)
Please include a copy of the front and back of the patient's insurance card(s).

☐ Physician Information (Section 4)
Complete with all relevant information and best contact person. Be sure to sign the **Physician Authorization**.

☐ Prescription Information (Section 5)
Please complete the selected prescription information for your patient by (1) indicating the drug and dosage, (2) indicating which patient support services your patient is interested in receiving, and (3) completing the prescription dosing section. Be sure to sign the **Prescription Information Signature** at the bottom of the page.

For KISQALI, see page 3. For RYDAPT, see page 4. For all other oral therapies, see page 5. For injectable therapies, see page 6.

WHAT TO EXPECT NEXT

When sending your Service Request Form to Novartis, please expect a call and/or fax from Patient Assistance Now Oncology (PANO) within **24 to 48 hours**.

NOVARTIS ONCOLOGY SERVICE REQUEST FORM FOR PATIENT SUPPORT

Please complete the Fax Cover Sheet and Service Request Form, and fax to 1-888-891-4924.
For additional questions, call 1-800-282-7630.

1. PATIENT INFORMATION (TO BE COMPLETED BY PATIENT)

Patient's First Name | Last Name | Middle Name

Street Address | **Sex:** ☐ Male ☐ Female

City, State, Zip | Date of Birth

Email

Home Phone | Cell Phone

☐ OK to leave detailed voice mail about your medication on your cell/home phone

Contact: ☐ Patient ☐ Patient Caregiver/Advocate ☐ Parent/Legal Guardian

Caregiver/Advocate Name | Caregiver/Advocate Phone

Caregiver/Advocate Street Address | Caregiver/Advocate City, State, Zip

2. NOVARTIS PATIENT ASSISTANCE FOUNDATION (NPAF)

Novartis is committed to providing access to Novartis medications for those most in need. If you are experiencing financial hardship and have limited or no prescription coverage, then you may be eligible to receive Novartis medications free.

☐ I do not wish to be considered for NPAF, which may provide medications for free, if eligible.

CANNOT PROCESS NPAF WITHOUT ONE OF THE FOLLOWING

Financial Documentation Options for verifying income to determine NPAF eligibility:

1) Check the Fair Credit Reporting Act consent below to allow for electronic income verification

OR

2) Provide financial documentation as indicated below:
Attach a copy of your household's most recent year's tax returns OR 3 months of paycheck stubs OR bank statements OR unemployment checks. **Do not send original documents with your form.**

Total number of people in the home (Including self, please add all those who are living with you)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

US Resident: ☐ Yes ☐ No Veteran: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No

Total Gross Monthly Household Income: $_____

PATIENT SIGNATURE

(REQUIRED)

PATIENT AUTHORIZATION – REQUIRED FOR PROCESSING PANO OR NPAF (IF SELECTED)

I confirm that the information provided herein is truthful and accurate to the best of my knowledge.

☐ I have read and agree to the Fair Crediting Reporting Act (FCRA) on page 10 (Optional)

☐ I have read and agree to the Telephone Consumer Protection Act (TCPA) Consent on pages 9-10 (Optional)

I have read and agree to the Patient Authorization (section B) on pages 7-10 on this document. If eligible and unless indicated above, I would like to be considered for NPAF, which may provide free access to my medication.

X _____

Patient/Legal Guardian Signature | MM/DD/YYYY

3. INSURANCE INFORMATION

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF THE PATIENT'S INSURANCE CARD(S)

Primary Insurance (PI) Name | PI Subscriber Name

Policy Holder DOB | Policy/Group #

PI Subscriber ID | PI Phone

Prescription Insurance (Medicare patients please use Medicare Part D information)

Member ID

Group | Phone

Pharmacy Services Phone (see back of card)

4. PHYSICIAN INFORMATION

First Name | Last Name

Practice/Institution Name | Specialty

Street Address | City, State, Zip

Office Contact Name | Office Contact Number

Office Fax Number | Office Email

Billing Information for: ☐ Group ☐ Individual

Tax ID # | NPI #

DEA #

PRESCRIBER SIGNATURE

(REQUIRED)

PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING

I have read and agree to the **Physician Authorization** (section A) on page 7 of this document.

X _____

Prescriber Signature (no stamps) | MM/DD/YYYY

Patient First Name | Patient Last Name | Patient Date of Birth | Prescriber Name | DEA # | Tax ID # or NPI #

5. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

KISQALI® (ribociclib) tablets

☐ **Rx: KISQALI® (ribociclib) tablets**
Tablet strength: 200 mg

KISQALI packaging comes in 28-day cycle packs, which include a 21-day supply of tablets, followed by 7 days off.
Please choose one of the following dose packs:

☐ KISQALI 600 mg Dose Pack: 3 tablets per day
☐ KISQALI 400 mg Dose Pack: 2 tablets per day
☐ KISQALI 200 mg Dose Pack: 1 tablet per day

Other Instructions _____
Refills Authorized _____
Primary Diagnosis/ICD-10-CM _____
Secondary Diagnosis/ICD-10-CM _____

☐ **Rx: KISQALI® (ribociclib) tablets FEMARA® (letrozole) tablets Co-Pack**
KISQALI tablet strength: 200 mg FEMARA tablet strength: 2.5 mg

KISQALI FEMARA Co-Pack packaging comes in 28-day cycle packs, which include a 21-day supply of KISQALI tablets, followed by 7 days off, and a 28-day supply of FEMARA tablets taken once daily throughout the 28-day cycle.
Please choose one of the following dose packs:

☐ KISQALI 600 mg and FEMARA 2.5 mg Dose Pack: 3 KISQALI tablets per day and 1 FEMARA tablet per day
☐ KISQALI 400 mg and FEMARA 2.5 mg Dose Pack: 2 KISQALI tablets per day and 1 FEMARA tablet per day
☐ KISQALI 200 mg and FEMARA 2.5 mg Dose Pack: 1 KISQALI tablet per day and 1 FEMARA tablet per day

Other Dosing Instructions _____
Refills Authorized _____
Primary Diagnosis/ICD-10-CM _____
Secondary Diagnosis/ICD-10-CM _____

Transfer prescription to patient's pharmacy*: Preferred Pharmacy: _____ Phone: _____
City: _____ State: _____ Fax: _____

*Subject to preferred pharmacy being within network for patient's prescription insurance.

KISQALI Patient Support Services

☐ **KISQALI Access Program**
Commercially insured patients who are taking KISQALI for an FDA-approved indication and are experiencing an insurance coverage delay may be eligible for free medication while awaiting coverage, for up to 5 months. Patients receiving benefits under Medicare, Medicaid, or any other federal or state program are not eligible for this offer. Participation is not a guarantee of availability of insurance coverage or alternative financial assistance. Offer is not contingent upon purchase requirements of any kind. Novartis reserves the right to rescind, revoke, or amend the program without notice.

Prescription Rx for KISQALI:
Tablet strength: 200 mg

Please choose one of the following dose packs:

☐ KISQALI 600 mg Dose Pack: 3 tablets per day
☐ KISQALI 400 mg Dose Pack: 2 tablets per day
☐ KISQALI 200 mg Dose Pack: 1 tablet per day

Other Instructions _____
Up to 4 refills

Prescription Rx for KISQALI FEMARA Co-Pack:
KISQALI tablet strength: 200 mg FEMARA tablet strength: 2.5 mg

Please choose one of the following dose packs:

☐ KISQALI 600 mg and FEMARA 2.5 mg Dose Pack: 3 KISQALI tablets per day and 1 FEMARA tablet per day
☐ KISQALI 400 mg and FEMARA 2.5 mg Dose Pack: 2 KISQALI tablets per day and 1 FEMARA tablet per day
☐ KISQALI 200 mg and FEMARA 2.5 mg Dose Pack: 1 KISQALI tablet per day and 1 FEMARA tablet per day

Other Dosing Instructions _____
Up to 4 refills

ACCESS PROGRAM SIGNATURE – MANDATORY FOR ACCESS PROGRAM PROCESSING
I certify that this therapy is medically necessary, is for an FDA-approved indication, and this information 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.

X _____
Prescriber Signature (no stamps) Date

KISQALI Care @ Home Monitoring
Patients who are taking KISQALI for an FDA-approved indication may be eligible to receive certain monitoring tests at their home for free. This program is not available for patients with Medicare, Medicaid, or any other federal or state program. Program not available for residents of Michigan or Rhode Island. Prescribing physician will be notified of results or if patient is unable to have the monitoring conducted at home. This program is subject to termination or modification at any time.

	Baseline?	Continued Tests per Label?†	Additional Follow-up Tests?	If Additional, Please Specify
ECG	☐	☐	☐	
Labs (CBC, LFT, Electrolytes)	☐	☐	☐	

†**Label requires:** **ECG:** Day 14 of Cycle 1 and Day 1 of Cycle 2 **CBC and LFT:** Day 14 of Cycle 1, Days 1 and 14 of Cycle 2, Day 1 of Cycles 3-6 **Electrolytes:** Day 1 of each cycle after baseline

PRESCRIBER SIGNATURES

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, agents, and NPAF, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____ - OR - X _____

Prescriber Signature (no stamps) ☐ **Dispense as written** MM/DD/YYYY

Prescriber Signature (no stamps) ☐ **May substitute** MM/DD/YYYY

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 Novartis Oncology Service Request Form.

Patient First Name | Patient Last Name | Patient Date of Birth

Prescriber Name | DEA # | Tax ID # or NPI #

5. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

RYDAPT® (midostaurin) capsules

Rx: RYDAPT® (midostaurin) capsules

Capsule strength: 25 mg

RYDAPT packaging comes in the following dose packs:

☐ RYDAPT Dose Pack: 56-capsule pack

☐ RYDAPT Dose Pack: 112-capsule pack

Primary Diagnosis/ICD-10-CM _____

Secondary Diagnosis/ICD-10-CM _____

Prior Treatment (if any) _____

Dosing Instructions: Take _____ capsule(s) _____ time(s) per day

Dispense # _____ # of days supplied _____

Refills Authorized _____

Please fill out completely:

Current Site of Care: ☐ Hospital (inpatient) ☐ Outpatient ☐ Other

Please specify if other _____

If currently inpatient, will patient soon be in outpatient setting? ☐ Yes ☐ No

Next scheduled cycle:

Projected start date _____

Projected RYDAPT start date _____

Has the patient been:

FLT3 tested? ☐ Yes ☐ No

FLT3 mutation detected? ☐ Yes ☐ No ☐ Awaiting results

Is the patient a candidate for allogeneic transplant? ☐ Yes ☐ No

Transfer prescription to patient's pharmacy*:

Preferred Pharmacy: _____ Phone: _____

City: _____ State: _____ Fax: _____

*Subject to preferred pharmacy being within network for patient's prescription insurance.

☐ **RYDAPT Free Supply Programs**

Patients who are taking RYDAPT in accordance with the FDA-approved prescribing information and are new to therapy or experiencing an insurance coverage delay may be eligible for a free supply of RYDAPT. Participation is not a guarantee of availability of insurance coverage or alternative financial assistance programs. Offer is not contingent upon purchase requirements of any kind. Novartis reserves the right to rescind, revoke, or amend this program without notice.

Prescription Rx for RYDAPT:

Capsule strength: 25 mg

☐ RYDAPT Dose Pack: 56-capsule pack (14-day supply for 28-day cycle)

☐ RYDAPT Dose Pack: 112-capsule pack x2 (28-day supply)

Dosing Instructions for 28-day trial:

Take ____ capsule(s) _____ time(s) per day for 28-day cycle

Dispense: 28-day cycle. Up to 2 refills. Terms and conditions vary based on diagnosis.

RYDAPT FREE SUPPLY PROGRAMS SIGNATURE – MANDATORY FOR RYDAPT FREE SUPPLY PROGRAMS PROCESSING

I certify that this therapy is medically necessary, is prescribed in accordance with the FDA-approved prescribing information, and this information 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.

X _____

Prescriber Signature (no stamps) | Date

PRESCRIBER SIGNATURES

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, agents, and NPAF, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____ - OR - X _____

Prescriber Signature (no stamps) | ☐ Dispense as written | MM/DD/YYYY

Prescriber Signature (no stamps) | ☐ May substitute | MM/DD/YYYY

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.

Patient First Name | Patient Last Name | Patient Date of Birth | Prescriber Name | DEA # | Tax ID # or NPI #

5. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Step 1: Please select product(s)	Step 2: Please indicate which specific support services your patient is interested in receiving (check all that apply)		Step 3: Please fill in the information below
	Patient Support Services		
	Benefits investigation and information about financial support	Free Trial Program	
☐ **Rx: AFINITOR® (everolimus) Tablets** Tablet strength (check one) ☐2.5 mg ☐5 mg ☐7.5 mg ☐10 mg	☐	☐ **14-Day***	Product _____ Primary Diagnosis/ICD-10-CM _____ Secondary Diagnosis/ICD-10-CM _____ Prior Treatment (if any) _____ Take _____ tablet(s)/capsule(s) _____ time(s) per day Quantity _____ # of days supplied _____ Refills Authorized _____
☐ **Rx: AFINITOR DISPERZ® (everolimus tablets for oral suspension)** Tablet strength (check one) ☐2 mg ☐3 mg ☐5 mg	☐	**Please refer to AfiniTRAC program**	
☐ **Rx: GLEEVEC® (imatinib mesylate) tablets** Tablet strength (check one) ☐100 mg ☐400 mg	☐	N/A	
☐ **Rx: TAFINLAR® (dabrafenib) capsules** Capsule strength (check one) ☐50 mg ☐75 mg	☐	☐ **30-Day***	**Please fill in if prescribing more than 1 product** Product _____ Primary Diagnosis/ICD-10-CM _____ Secondary Diagnosis/ICD-10-CM _____ Prior Treatment (if any) _____ Take _____ tablet(s)/capsule(s) _____ time(s) per day Quantity _____ # of days supplied _____ Refills Authorized _____
☐ **Rx: MEKINIST® (trametinib) tablets** Tablet strength (check one) ☐0.5 mg ☐2 mg	☐	☐ **30-Day***	
☐ **Rx: PROMACTA® (eltrombopag) tablets** Tablet strength (check one) ☐12.5 mg ☐25 mg ☐50 mg ☐75 mg	☐	N/A	
☐ **Rx: JADENU® (deferasirox) tablets** Tablet strength (check one) ☐90 mg ☐180 mg ☐360 mg	☐	N/A	
☐ **Rx: JADENU® Sprinkle (deferasirox) granules** Granule strength (check one) ☐90 mg ☐180 mg ☐360 mg	☐	N/A	**In addition to the information above, please fill in if prescribing JADENU, JADENU Sprinkle, or EXJADE:** Patient weight (kg) _____ Total daily dose for JADENU or JADENU Sprinkle _____ (must be divisible by 90 mg) Total daily dose for EXJADE _____ (must be divisible by 125 mg)
☐ **Rx: EXJADE® (deferasirox) tablets for oral suspension** Tablet strength (check one) ☐125 mg ☐250 mg ☐500 mg	☐	N/A	
☐ **Rx: TASIGNA® (nilotinib) capsules** Capsule strength (check one) ☐150 mg ☐200 mg	☐	N/A	
☐ **Rx: TYKERB® (lapatinib) tablets** Tablet strength 250 mg	☐	☐ **14-Day***	
☐ **Rx: VOTRIENT® (pazopanib) tablets** Tablet strength 200 mg	☐	☐ **14-Day***	
☐ **Rx: ZYKADIA® (ceritinib) capsules** Capsule strength 150 mg	☐	☐ **14-Day***	
☐ **Rx: Other Novartis Oncology Product** _____ Dosage strength _____	☐	N/A	

***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. Please sign the Prescription Information Signature.**

PRESCRIBER SIGNATURES

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, agents, and NPAF, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____ — OR — X _____

Prescriber Signature (no stamps) ☐ Dispense as written MM/DD/YYYY | Prescriber Signature (no stamps) ☐ May substitute MM/DD/YYYY

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.

Patient First Name | Patient Last Name | Patient Date of Birth | Prescriber Name | DEA # | Tax ID # or NPI #

5. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Step 1: Please select product(s)	Step 2: Please indicate which specific support services your patient is interested in receiving (check all that apply)	Step 3: Please fill in the information below
	Patient Support Services	
☐ **Rx: Sandostatin® LAR Depot (octreotide acetate for injectable suspension)** Dosage strength (check one) ☐ 10 mg ☐ 20 mg ☐ 30 mg	☐	ICD/10 _____ Directions: ☐ Administer _____ mg by intramuscular injection once every 4 weeks (every 28 days) Quantity _____ # of refills authorized _____
☐ **Rx: SIGNIFOR® LAR (pasireotide) for injectable suspension** Dosage strength (check one) ☐ 20 mg ☐ 40 mg ☐ 60 mg	☐	
☐ **Rx: SIGNIFOR® (pasireotide) injection** Dosage strength (check one) ☐ 0.3 mg ☐ 0.6 mg ☐ 0.9 mg	☐	ICD/10 _____ Directions: ☐ Administer _____ mg by subcutaneous injection twice a day Quantity _____ 30-day supply kit: 60 (1-mL) syringes, 60-18 G long needles, 60-27 G short needles, 60 alcohol swabs, Sharps box. Directions: ☐ Use as directed For each refill include a 30-day supply kit. Number of refills per shipment _____

Mobile Administration Program for Eligible Sandostatin LAR Depot or SIGNIFOR LAR Patients†:

☐ Yes, I would like a home health nurse to administer **Sandostatin LAR Depot** or **SIGNIFOR LAR** at the patient's home or other location.

For _____ visits beginning _____

Injection administered at:

☐ Patient's home address (see Patient Information on page 2)

☐ Other (please list street address)

_____

†Limitations apply. Available only for patients with commercial insurance. Program not available for patients with Medicare, Medicaid, or any other federal or state program. Program not available for residents of Massachusetts, Michigan, Minnesota, or Rhode Island.

Self-Injection Home Education for SIGNIFOR patients:

☐ Yes, I would like the patient to receive education on the administration of **SIGNIFOR** at the patient's home (see Patient Information on page 2)

PRESCRIBER SIGNATURES

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, agents, and NPAF, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____ — OR — X _____

Prescriber Signature (no stamps) ☐ **Dispense as written** MM/DD/YYYY

Prescriber Signature (no stamps) ☐ **May substitute** MM/DD/YYYY

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.

A. PHYSICIAN AUTHORIZATION

My signature on page 2 certifies that I am the physician who has prescribed the selected drug to the patient identified on page 2. 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 on page 2.

NOVARTIS PATIENT ASSISTANCE FOUNDATION (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.

B. PATIENT AUTHORIZATION

Please read the following carefully, then sign and date where indicated on page 2.

I give permission for my healthcare providers (HCPs), pharmacies, service providers and their contractors (“Healthcare Providers”), health insurer(s) and their contractors (“Insurers”) and third-party contractors, to disclose my personal information, including information about my insurance benefits, prescriptions, my medical condition and history, adherence to my treatment and my general health (“Personal Information”) to Novartis Pharmaceuticals Corporation, its affiliates, business partners, agents, and the Novartis Patient Assistance Foundation, Inc. (collectively, the “Companies”) so that the Companies may:

i. help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with the product selected by my HCP on this form,

ii. coordinate my receipt of and payment of the product selected by my HCP on this form,

iii. facilitate my access to the product selected by my HCP on this form,

iv. provide me with information about Novartis products, disease education and management programs and promotional materials,

v. if I am eligible, coordinate the Novartis Oncology Universal Co-pay Program, including managing and communicating with me about the copay support options available to me,

vi. provide me with medication reminders and support,

vii. conduct quality assurance, surveys, and other internal business activities in connection with PANO and the Companies and other related programs; and

viii. if I choose to apply to programs offered by the Companies, to administer those programs, to send me information about programs that might help me pay for medicines, and to coordinate or share my Personal Information with my health care providers, other programs that might help me pay for medicines, government agencies, and insurance companies for purposes of providing or facilitating this assistance.

I give permission to the Companies to disclose my Personal Information to my Healthcare Providers, insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above. I also give permission to the Companies to combine or aggregate any information collected from me with information Novartis may collect about me from other sources for the purpose of providing or administering Program services.

I understand that some of my pharmacies or other health care providers may receive payment from the Companies depending on my enrollment or participation in therapy support services such as prescription refill reminders. I understand that once my Personal Information is disclosed, it may no longer be protected by federal privacy law and applicable state laws. Even though HIPAA may no longer apply, the Companies will safeguard patient data through reasonable security measures and will use and share it only for the purposes specified in this Authorization.

I understand that I may refuse to sign this authorization. I also may revoke (cancel) or get a copy of this authorization at any time by calling at 1-800-282-7630 or by writing to McKesson, PO Box 29238, Phoenix, AZ 85038-9238. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Healthcare Provider or Insurer is disclosing my Personal Information to the Companies on an authorized, ongoing basis, my cancellation with the Companies will be effective with respect to any such Healthcare Provider or Insurer as soon as they receive notice of my cancellation.

My refusal or future revocation will not affect my medical treatment or insurance benefits; however, if I revoke this authorization, I may no longer be able to participate in PANO and related programs. If I revoke this authorization, the Companies will stop using or sharing my information (except as necessary to end my participation in the program), but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier. I also understand that PANO may change or end at any time without prior notification. I understand that I may

receive a copy of this Patient Authorization.

I agree to be contacted by the Companies by mail, email, telephone calls and text messages at the numbers and addresses provided on this Form for all purposes described in this Patient Authorization. I also agree to be contacted by the Companies, and others on its behalf by telephone calls and text messages made by or using automatic telephone dialing machines or artificial or prerecorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys.

I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to notify the Companies promptly if any of my number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that the Companies do not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by email and cell phone cannot be secured against unauthorized access.

TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT (OPTIONAL)

I consent to receive marketing calls and texts from and on behalf of the Companies, made with an auto dialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Number of messages will vary based on your program selections. Message and data rates may apply. Text STOP to opt out and HELP for help.

TERMS AND CONDITIONS FOR TCPA-RELATED ACTIVITIES

By signing up to receive marketing texts and calls, or by requesting information by telephone, text message, fax, email, direct mail or other means, you accept, without limitation or qualification, that:

- You and Novartis agree that any legal disputes or claims arising out of or related to the Terms and Conditions, or the use of the Novartis products and/or the Services (including but not limited to telephone calls or text messages sent by Novartis), or the interpretation, enforceability, revocability, or validity of the Terms and Conditions, or the arbitrability of any dispute, that cannot be resolved informally shall be submitted to binding arbitration in the state in which the Terms and Conditions was performed. The arbitration shall be conducted by the American Arbitration Association under its Commercial Arbitration Rules.
- This arbitration clause is an independent agreement and shall survive the termination and/or transfer of these Terms and Conditions or any other agreement between you and Novartis. If any provision of the agreement to arbitrate in this Section is found unenforceable, the unenforceable provision will be severed and the remaining arbitration terms will be enforced (but in no case will there be a class, representative or private attorney general arbitration). Any judgment on the award rendered

by the arbitrator may be entered in any court having jurisdiction thereof. Claims shall be brought within the time required by applicable law. The laws of the State of New York will govern the Terms and Conditions and the Federal Arbitration Act, 9 U.S.C. §§ 1-16, will govern this Section, without giving effect to any principles of conflicts of laws. Each party shall bear its own costs relating to the arbitration consistent with the Commercial Arbitration Rules of the American Arbitration Association.

- You and Novartis agree that any claim, action or proceeding arising out of or related to the Terms and Conditions or telephone calls or text messages sent by Novartis must be brought in your individual capacity, and not as a plaintiff or class member in any purported class, collective, or representative proceeding. The arbitrator may not consolidate more than one person's claims, and the arbitrator may not otherwise preside over any form of a representative, collective, or class proceeding.

YOU ACKNOWLEDGE AND AGREE THAT YOU AND NOVARTIS ARE EACH WAIVING THE RIGHT TO A TRIAL BY JURY OR TO PARTICIPATE AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS ACTION OR REPRESENTATIVE PROCEEDING.

FAIR CREDIT REPORTING ACT (FCRA) AUTHORIZATION (FOR NPAF PROGRAMS ONLY)

I understand that I am providing "written instructions" authorizing the Companies and its vendor, under the FCRA, to obtain information from my credit profile or other information from Experian Health, solely for the purpose of determining financial qualifications for programs administered by NPAF. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide are complete and true.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080