

PATIENT AUTHORIZATION AND CONSENTS

1 Patient Information

First Name	Last Name
/ /	
Date of Birth (MM/DD/YYYY)	ZIP
Email	

2 Patient Authorization and Additional Consents

I have read and agree to the Patient Authorization on page 2.

→ X

Patient/Legal Guardian Signature

Date of Signature (MM/DD/YYYY)

KESIMPTA Copay Card Program

I have read and agree to the Copay Program Terms and Conditions on page 2.

Determine financial eligibility

Novartis Patient Assistance Foundation, Inc., (NPAF) provides free KESIMPTA to eligible uninsured and underinsured patients. Proof of income is required. If you choose to apply for free KESIMPTA, checking the box below will prompt NPAF to verify your income.

I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization on page 2.

Ongoing Support from Alongside KESIMPTA

We'll check in with you via calls and texts to support your start with KESIMPTA. You can also get continued one-on-one support with a dedicated Alongside KESIMPTA Coordinator by checking the box below.

I want to receive recurring reminders, tips, and other communications via calls and texts at the phone number provided. I understand calls or texts may be autodialed or prerecorded and are not a condition of purchase.



Complete the entire form and fax it to
Alongside KESIMPTA at **1-833-642-0460**

We've got your back.



Questions?

Call us at 1-855-KESIMPTA (1-855-537-4678)
8:30 AM–8:00 PM ET, Monday–Friday



Visit www.KESIMPTA.com
for more information

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 copay 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 1-855-537-4678 or writing to:

PO Box 2971
850 Twin Rivers Dr
Columbus, OH, 43216-9532

OR

Customer Interaction Center
Novartis Pharmaceuticals Corporation
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.

I agree for myself and certify (if applicable) that my caregiver agrees to receive non-marketing calls and texts from Novartis or NPAF, including through an autodialer or prerecorded voice, at the number(s) provided.

Copay Program Terms and Conditions

Limitations apply. Valid only for those with private insurance. The Program includes the copay card and Rebate, with a combined annual limit of \$18,000. Patient is responsible for any costs once limit is reached in a calendar year. Program not valid (i) under Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program, (ii) where patient is not using insurance coverage at all, (iii) where the patient’s insurance plan reimburses for the entire cost of the drug, or (iv) where product is not covered by patient’s insurance. The value of this Program is exclusively for the benefit of patients and is intended to be credited toward patient out-of-pocket obligations and maximums, including applicable copayments, coinsurance, and deductibles. Program is not valid where prohibited by law. Patient may not seek reimbursement for the value received from this Program from other parties, including any health insurance program or plan, flexible spending account, or health care savings account. Patient is responsible for complying with any applicable limitations and requirements of their health plan related to the use of the Program. Valid only in the United States and Puerto Rico. This Program is not health insurance. Program may not be combined with any third-party rebate, coupon, or offer. Proof of purchase may be required. Novartis reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

Fair Credit Reporting Act (FCRA) Authorization

I understand that I am providing “written instructions” that authorize NPAF and its vendor, under the FCRA, to obtain information from my credit profile or other information from the vendor, 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 with this financial screening process.

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