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: 1-866-253-1410

***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* VIJOICE® (alpelisib) tablets

Please choose 1 of the following dose packs*: ○ 50 mg once daily ○ 125 mg once daily ○ 250 mg once daily

Primary Diagnosis* ○ PROS (PIK3CA-Related Overgrowth Spectrum) ○ Other:

Refills Authorized*

Other Instructions

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

Free Trial ☐ Yes

Patients who are taking VIJOICE 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 VIJOICE. 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. The supply can be shipped directly to patients so they can start treatment immediately. Dispense: 28-day cycle. Up to 1 refill. Terms and conditions vary based on diagnosis.

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.

I have discussed PANO with my patient, who has authorized me under HIPAA and state law to disclose their information to Novartis for the limited purpose of enrolling in Patient PANO. To complete this enrollment, Novartis may contact the patient by phone, text and/or email.

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: _____

Rx

VIJOICE® (alpelisib) tablets

- ○ 50 mg once daily
- ○ 125 mg once daily
- ○ 250 mg once daily

Other Instructions: _____

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: _____

Rx

VIJOICE® (alpelisib) tablets

- ○ 50 mg once daily
- ○ 125 mg once daily
- ○ 250 mg once daily

Other Instructions: _____

Quantity: 28-Day Supply 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, is prescribed in accordance with the FDA-approved prescribing information, using an appropriate FDA-approved test, 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.

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

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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