

Please check one of the following boxes*:

☐ I am a new patient

☐ I am re-enrolling

1 Patient Information

* = REQUIRED FIELDS

First Name*		Last Name*		Email	
/ /		Sex for Clinical Use*: ☐ Male			
Date of Birth (MM/DD/YYYY)*		☐ Female		Mobile Number* (preferred)—For non-marketing calls/texts. [†]	
Patient Home/Shipping Address* (No PO Box)				Alternate Phone Number*—(If no mobile number is available)	
City*	State*	ZIP*	Household Size*—As determined on your tax return (1040)		
Preferred Language for NPAF Communications: ☐ English ☐ Spanish ☐ Other (please specify):					
Reside in the US or US Territory*: ☐ Yes ☐ No					
If Yes is checked, you must provide a copy of documentation. Preferred documentation includes the following: state-issued driver's license, government-issued ID, utility bill, or green card.					
I give permission to disclose my personal health information to the following authorized caregiver, legal guardian, or medical power of attorney:					
Name		Relationship to Patient		Phone Number	

2 Insurance Information

Insurance card is required for complete application: please include copies (front and back) of **all** insurance card(s). This includes primary, secondary, and prescription insurance.

Insurance Status and Information Status

☐ Uninsured. I do not have health insurance coverage

☐ I have government insurance: Copies of all insurance cards (front and back), including Medicare (Red/White/Blue) card, primary, secondary, and prescription insurance plans, are required.

3 Income

Eligibility for the Novartis Patient Assistance Foundation (NPAF) program requires that you provide your proof of income. You must submit a copy of the first 2 pages of your most recent tax return (1040). If you are not required to file taxes, please contact NPAF directly to discuss next steps.*

4 Healthcare Provider (HCP) Information

HCP First Name*	HCP Last Name*	HCP Phone Number	
HCP Address*	City*	State*	ZIP*

5 Patient Authorization

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



Patient/Legal Guardian Signature*

Date (MM/DD/YYYY)

Complete the entire form and submit to NPAF. For the latest application and ways to submit go to www.PAP.Novartis.com.
An incomplete form will result in a processing delay or application denial.

Patient Authorization

I authorize my health care 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 to confirm or identify insurance, assist with processing my information to confirm eligibility, and if approved, coordinate delivery of my medication.
- Communicate with me about possible financial assistance, or NPAF programs, and, if I am enrolled, administer my participation in those programs.
- Communicate with me about my medication and treatment, including reminders 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 health care 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 that I must provide consent to process this application. However, I understand 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:

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. For Maryland health care providers, this authorization expires 1 year from the date of signature. 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.

¹Novartis 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.

NPAF is an independent, 501(c)(3) non-profit entity that provides certain medications at no cost to eligible patients who cannot afford the cost of their Novartis medication, are uninsured or have government insurance, and meet income guidelines and other eligibility criteria. NPAF does not provide product to individuals having insurance associated with any type of alternative funding program that conditions, restricts, or adjusts coverage based on application to NPAF or any other free goods program. Other terms and conditions may apply.

To receive support through NPAF, applicants must submit all required documentation, including proof of income and evidence of Extra Help denial as deemed necessary. Only the patient or their legal guardian or caregiver may enroll the patient in the program. Health plans, specialty pharmacies, pharmacy benefit managers, and their agents and representatives are prohibited from enrolling patients in the program. Novartis Patient Assistance Foundation, Inc., at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of enrollment information submitted. Please visit www.PAP.Novartis.com for more information.

1 Prescriber Information

★ = REQUIRED FIELDS

First Name★		Last Name★		Practice Name★	
Prescriber Address (where patient is being treated)★				Practice Phone Number★	
City★	State★	ZIP★	Office Contact Name		Office Contact Phone
Prescriber NPI Number★			Office Fax★		
State License Number			Office Email		

2 Site of Administration Information (Outpatient Facility, Physician's Office, Home Infusion, Other)

If you intend to send your patient to another site to receive treatment, please complete the information below.

Site Name★		Site Contact Name★	
Site Address (where patient is being treated)★		Site Phone Number★	
City★	State★	ZIP★	Site Fax★
Site Provider NPI Number★			

3 Patient Information

First Name★	Last Name★	/ / Sex for Clinical Use★: ☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)★		
Patient Home/Shipping Address★ (No PO Box)		City★ State★ ZIP★

4 Product Requested

Novartis Patient Assistance Foundation (NPAF) only accepts ePrescribe as a valid prescription. This form does not serve as a prescription.
If patient is approved, NPAF will provide you with ePrescribe directions.

Medication Brand Name★	Strength★	Quantity★	Days Supply★	Diagnosis (ICD-10 Code)★
	If an injectable: ☐ Pen ☐ Syringe ☐ Vial Strength: _____	Quantity: _____	Days Supply: _____	Primary: _____ Secondary: _____
	If an injectable: ☐ Pen ☐ Syringe ☐ Vial Strength: _____	Quantity: _____	Days Supply: _____	Primary: _____ Secondary: _____

5 Prescriber Attestation

Prescriber must authorize these instructions and acknowledge that they have read and agree to the Prescriber Attestation on page 4 by signing at the end of this section.

X	/ /
Prescriber Signature★	Date (MM/DD/YYYY)

Complete the entire form and submit to NPAF. For the latest application and ways to submit go to www.PAP.Novartis.com.
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Prescriber Attestation

I certify that the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify that I am the provider who has prescribed the drug identified above to the patient named on this form. I certify that any medication received from Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") or the Novartis Patient Assistance Foundation, Inc. and its service providers ("NPAF"), will be used only for the patient named on this form and will not be offered for sale, trade, or barter, returned for credit, or submitted for reimbursement in any form. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Novartis and NPAF may revise, change, or terminate their respective programs at any time.

I have discussed NPAF 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 NPAF. To complete this enrollment, Novartis may contact the patient by phone, text, or email.

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