Reset Form

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.**

UPDATE: KISQALI® (ribociclib) tablets added on page 3
RYDAPT® (midostaurin) capsules added on page 5
SIGNIFOR® (pasireotide) injection and SIGNIFOR® LAR (pasireotide) for injectable suspension added on page 9

Please complete the Fax Cover Sheet and Service Request Form, and fax all pages 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, also known as the Patient Assistance Program (PAP). Please review the Financial Documentation Options to determine how the patient would like us to verify income. Be sure the patient signs the **Patient Assistance Program (PAP) Consent For Patient** (if applicable).

☐ 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**, and if the patient is applying, the **Patient Assistance Program (PAP) Consent For Physician**.

☐ 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 5. For all other oral therapies, see page 7. For injectable therapies, see page 9.

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 all pages 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

E-mail

Home Phone | Cell Phone

Contact me by: ☐ Cell Phone ☐ Home Phone ☐ E-mail

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Language Preference

Contact: ☐ Patient ☐ Patient Caregiver/Advocate

Caregiver/Advocate Name | Caregiver/Advocate Phone

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

PATIENT SIGNATURES

(REQUIRED)

PATIENT AUTHORIZATION – MANDATORY FOR PROCESSING

I have read and agree to the **Patient Authorization** (section C) on pages 6 and 8 of this document.

X _____

Patient Signature | Date

2. NOVARTIS PATIENT ASSISTANCE FOUNDATION (NPAF)

(FOR PATIENTS APPLYING FOR PAP)

PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PATIENT

I have read and agree to the **Patient Assistance Program (PAP) Consent For Patient** (section D) on pages 8 and 10 of this document. I promise that any information, including financial and insurance information that I provide, are complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call NPAF at 1-800-277-2254.

☐ I have read and agree to the Novartis Patient Assistance Foundation, Inc., TCPA Consent on page 10 (optional)

☐ I have read and agree to the Novartis Patient Assistance Foundation, Inc., FCRA Authorization on page 10 (optional)

X _____

Patient Signature | Date

Financial Documentation Options for verifying income to determine NPAF eligibility:
1) Check the Fair Credit Reporting Act consent above 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: $_____

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 E-mail

Billing Information for: ☐ Group ☐ Individual

Tax ID # | NPI #

DEA #

PRESCRIBER SIGNATURES

(REQUIRED)

PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING

I have read and agree to the **Physician Authorization** (section A) on page 4 of this document.

X _____

Prescriber Signature (no stamps) | Date

NOVARTIS PATIENT ASSISTANCE FOUNDATION (NPAF)
PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PHYSICIAN – SIGNATURE ONLY REQUIRED FOR PATIENTS APPLYING FOR PAP

I have read and agree to the **Patient Assistance Program (PAP) Consent For Physician** (section B) on page 4 of this document.

X _____

Prescriber Signature (no stamps) | Date

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.

Is your patient interested in applying for the Patient Assistance Program (PAP) for low-income and uninsured patients?
☐ Yes ☐ No

Make sure you and your patient sign the Patient Assistance Program Consent on page 2 and that the Patient Financial Information is provided. Also make sure to sign the Prescription Information Signature below.

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, and agents, 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** Date

Prescriber Signature (no stamps) ☐ **May substitute** Date

NOTE: DE, NY, and NJ prescribers, or any other state where this is a requirement, must 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, and agents, 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.

B. PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PHYSICIAN
(MANDATORY FOR PATIENTS ENROLLING IN THE PATIENT ASSISTANCE PROGRAM)

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.

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.

Is your patient interested in applying for the Patient Assistance Program (PAP) for low-income and uninsured patients?

☐ Yes ☐ No

Make sure you and your patient sign the Patient Assistance Program Consent on page 2 and that the Patient Financial Information is provided. Also make sure to sign the Prescription Information Signature below.

☐ **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, and agents, 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** Date

Prescriber Signature (no stamps) ☐ **May substitute** Date

NOTE: DE, NY, and NJ prescribers, or any other state where this is a requirement, must submit a state-approved prescription with this completed form.
NOTE: Depending on selected programs, additional prescriptions may be required.

C. PATIENT AUTHORIZATION FOR PATIENT SUPPORT SERVICES

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

I give permission for my health care providers (HCPs), pharmacies, health insurer(s), and third-party contractors or service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates, business partners, service providers, third-party contractors, and agents (together, the "Novartis Group") so that the Novartis Group can provide me with the Patient Support Services available for the Novartis Oncology medication prescribed by my HCP on this Service Request Form to (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with this Novartis Oncology medication, (ii) coordinate my receipt of, and payment for this Novartis Oncology medication, (iii) facilitate my access to this Novartis Oncology medication, (iv) provide me with information about this Novartis Oncology medication, disease awareness and management programs and educational materials, (v) manage the Patient Support Services, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the Patient Support Services.

I give permission to the Novartis Group to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from the Novartis Pharmaceuticals Corporation in exchange for disclosing my Personal Information to Novartis Pharmaceuticals Corporation and/or for providing me with therapy support services.

I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by calling 1-888-NOW-NOVA (1-888-669-6682) or by writing to the Customer Interaction Center, Novartis Pharmaceuticals Corporation, One Health Plaza, East Hanover, NJ 07936-1080. My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctor(s); however, if I revoke this authorization, I may no longer be eligible to participate in the Patient Support Services. If I revoke this authorization, the Novartis Group will stop using or sharing my information (except as necessary to end my participation in the Services) but my revocation will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that the Patient Support Services may change or end at any time without prior notification. I understand that I have the right to receive a copy of this form.

I agree to be contacted by the Novartis Group by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Service Request Form for all purposes described in this Patient Authorization. I also agree to be contacted by the Novartis Group and on its behalf by telephone calls and text messages made using an automatic telephone dialing system or prerecorded voice, at the number(s) provided on the Service Request 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 e-mail address(es) provided, and I agree to notify the Novartis Group 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.

(continued on page 8)

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		Patient Assistance Program	
	Benefits investigation and information about financial support	Free Trial Program	Patient Assistance Program (PAP) for low-income and uninsured patients†	
☐ **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: 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*	☐	
☐ **Rx: MEKINIST® (trametinib) tablets** Tablet strength (check one) ☐ 0.5 mg ☐ 2 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: 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	☐	
☐ **Rx: EXJADE® (deferasirox) tablets for oral suspension** Tablet strength (check one) ☐ 125 mg ☐ 250 mg ☐ 500 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: TASIGNA® (nilotinib) capsules** Capsule strength (check one) ☐ 150 mg ☐ 200 mg	☐	N/A	☐	
☐ **Rx: TYKERB® (lapatinib) tablets** Tablet strength 250 mg	☐	☐ 14-Day*	☐	***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.** †Make sure you and your patient sign the Patient Assistance Program Consent on page 2 and that the Patient Financial Information is provided. Also make sure to sign the Prescription Information Signature below.
☐ **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	☐	

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, and agents, 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 Date | Prescriber Signature (no stamps) ☐ May substitute Date

NOTE: DE, NY, and NJ prescribers, or any other state where this is a requirement, must submit a state-approved prescription with this completed form.
NOTE: Depending on selected programs, additional prescriptions may be required.

(continued from page 6)

I understand that Novartis Pharmaceuticals Corporation does 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 e-mail and cell phone cannot be secured against unauthorized access.

D. PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PATIENT
(MANDATORY FOR PATIENTS ENROLLING IN THE PATIENT ASSISTANCE PROGRAM)

I give permission for my health care providers (HCPs), pharmacies, health insurer(s), third-party contractors, and service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to the Novartis Patient Assistance Foundation, Inc. ("NPAF") so that NPAF can administer those programs if I choose to apply and I am eligible, send me information about programs that might help me pay for my medicines, and to coordinate and share my Personal Information with my HCPs, 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 NPAF to disclose my Personal Information to my HCPs, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above. I also give permission to NPAF to combine or aggregate any information collected from me with information NPAF may collect about me from other sources for the purpose of providing or administering program services.

I understand that once my Personal Information is disclosed it may no longer be protected by federal and state privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization with respect to NPAF at any time in the future by calling 1-800-277-2254.

My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctors; however, if I revoke this authorization, I may no longer be able to participate in programs administered by NPAF. If I revoke this authorization, NPAF will stop using or sharing my information (except as necessary to end my participation in NPAF) 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 five (5) years after the date of my signature, unless I revoke it earlier. I also understand that programs administered by NPAF may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

I agree to be contacted by NPAF by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the NPAF application for all purposes described in this Patient Authorization. I also agree to be contacted by NPAF and others on its behalf by telephone calls and text messages made by or using an automatic telephone dialing system or prerecorded voice, at the number(s) provided on this form, for all nonmarketing 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 e-mail address(es) provided, and I agree to notify NPAF promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that NPAF does 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 e-mail and cell phone cannot be secured against unauthorized access.

(continued on page 10)

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	Patient Assistance Program (PAP) for low-income and uninsured patients†	
☐ **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 _____

†Make sure you and your patient sign the Patient Assistance Program Consent on page 2 and that the Patient Financial Information is provided.

Nurse Home Administration 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, and agents, 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** Date

Prescriber Signature (no stamps) ☐ **May substitute** Date

NOTE: DE, NY, and NJ prescribers, or any other state where this is a requirement, must submit a state-approved prescription with this completed form.
NOTE: Depending on selected programs, additional prescriptions may be required.

(continued from page 8)

Telephone Consumer Protection Act (TCPA) Consent

I consent to receive marketing and nonmarketing calls and texts from and on behalf of NPAF, made with an autodialer 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.

Fair Credit Reporting Act (FCRA) Authorization

I understand that I am providing "written instructions" authorizing NPAF 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.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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