Novartis Patient Support™

COSENTYX® (secukinumab) Provider Claim Payment Request Form

Novartis Patient Support Claims Processing Department
430 Mountain Avenue, Suite 105, New Providence, NJ 07974. Telephone: 877-793-7012 Fax: 631-822-2893

Please complete this form and submit with all required information and attachments to be considered for reimbursement. Please see page 2 for full program Terms and Conditions.

1. To receive payment* for the benefit of, and on behalf of, your patient in an amount equal to your eligible patient's qualifying† out-of-pocket expenses for medication covered under the medical benefit as "buy-and-bill," the **following health care provider information in BOLD is REQUIRED**.

Please fill out this form for co-pay reimbursement for COSENTYX and make sure to acknowledge and agree with the provider signature at the bottom. If a physician is affiliated with another site, this form will need to be filled out again for the other site with the provider signature at the bottom.

2. Please **fax** the following documents along with this form to 631-822-2893 to complete the process. Payments will **not** be processed without the following items:

   The Explanation of Benefits (EOB), which must include:
   - Patient name
   - Drug name
   - Date of service

   If the above is not included in the EOB, please additionally submit a copy of the CMS-1550 or CMS-1450/UB-04 form.

Health Care Provider Information			
Provider Last Name:		**Provider First Name:**	
Provider's NPI:		**Provider's State License #:**	
Site Name:		**Site NPI:**	
Email:		**Site Address:**	
Site City:		**Site State and ZIP Code:**	
Group #:		**Patient Rx ID #:**	

NPI=National Provider Identifier.

*Reimbursement by check only via this form.

Provider Last Name:		Provider First Name:	

Co-Pay Plus for COSENTYX® (secukinumab) Terms & Conditions

†Offer valid only when used with commercial health insurance. Offer is not available where:

- the patient has federal or state health plan benefits (*eg*, Medicare, Medicaid, TRICARE, VA);
- the health plan reimburses for the entire cost of the drug;
- the health plan provides no coverage for the drug; or
- prohibited by law.

The amount of funding available from the Program is subject to an annual limit. Novartis reserves the right to discontinue the availability of co-pay assistance if, at any time, Novartis determines that the patient is subject to a co-pay maximizer program. Co-pay maximizers are programs implemented by health plans in which the amount of the patient's out-of-pocket cost is increased to reflect the availability of support offered by a manufacturer assistance program. The patient is responsible for all costs once available funding from the Program is exhausted.

The Program is designed exclusively for the benefit of the patient. The amount of available funding may be reduced or eliminated if it is not credited by the patient's health plan toward the patient's out-of-pocket obligations (*eg*, deductibles, annual out-of-pocket maximums). Program funding may also be reduced or eliminated if the patient's health plan, directly or indirectly, adjusts, reduces, or waives the patient's health plan benefits based on the availability of, or the patient's enrollment in, the Program, or otherwise acts in a manner that materially affects these Terms and Conditions.

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 (individually and collectively "Plan Administrators"), are prohibited from enrolling patients in the Program.

Patients in the Program are responsible for notifying Novartis of any change in their prescription drug health plan coverage that may conflict or otherwise affect compliance with these Terms and Conditions. By accepting Program funding from Novartis on behalf of participating patients, Plan Administrators agree to not take any action that materially affects compliance with these Terms and Conditions.

Patients may not seek reimbursement for the value received from the Program from any other party (*eg*, health plans, flexible spending or healthcare savings accounts). Patients are responsible for complying with any applicable limitations and requirements of their health plan related to their use of the Program.

Valid only in the United States and Puerto Rico. Co-pay support for infusion administration cost not available in Rhode Island or Massachusetts.

The Program is not health insurance, and may not be combined with any third-party rebate, coupon, or offer. Novartis reserves the right to rescind, revoke, or amend the Program at any time without notice.

Provider Last Name:		Provider First Name:	

Certification Statement

I certify that the information provided herein is accurate; that expenses requested for payment are eligible, actually incurred, and not paid by the patient's insurance, Flexible Spending Account, Health Savings Account or any other health plan; and that I would, in the ordinary course of my practice, have charged my patient for such out-of-pocket expenses. I also certify that every patient for whom I submit for co-pay reimbursement and receive co-pay reimbursement (i) is not insured under Medicare, Medicaid, TRICARE, or any other government (state or federally funded) program; and (ii) meets the other eligibility criteria specified in the Terms & Conditions. I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

Acknowledged and agreed (*signature required*):

_____ Date:_____

Please allow 4-6 weeks for processing and payment of claims.