Novartis
Patient Support™

COSENTYX® (secukinumab) Specialty Pharmacy Claim Payment 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 payment.* 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 pharmacy benefit, the **following patient and specialty pharmacy information in BOLD is REQUIRED**.

2. Please **fax** the following documents 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
- Pharmacy documentation, which must include:
  - Patient name, address, date of birth
  - Drug name with NDC
  - Date of service
  - Receipt/invoice with balance due
- Front and back copies of the patient's insurance card(s)

If the above is not included in the EOB, please additionally submit a copy of the CMS-1500 or CMS-1450/UB-04 form.

Patient Information			
Patient Last Name:		**Patient First Name:**	
Patient Date of Birth:		**Patient ZIP Code:**	
Sex for Clinical Use:	☐ **Male** ☐ **Female**	**Patient Responsibility Amount ($):**	
Group #:		**Patient Rx ID #:**	

Specialty Pharmacy Information			
Pharmacy Name:		**Pharmacy Address:**	
Pharmacy City:		**Pharmacy State and ZIP Code:**	
Pharmacy Phone #:		**Pharmacy NABP/NPI:**	

NDC=National Drug Code, NABP=National Association of Boards of Pharmacy; NPI=National Provider Identifier.

*Payment by check only via this form.

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Patient Last Name:		Patient First Name:	

Co-Pay Plus 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.

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Patient Last Name:		Patient First Name:	

Certification Statement

I certify that the information provided is accurate; I also certify that the above-referenced patient (i) is not insured under Medicare, Medicaid, TRICARE, any other government (state or federally funded) program; and (ii) meets the other eligibility criteria specified under Step 1 above. 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. Successful claims will be processed and paid in the subsequent billing cycle.