**Sign up online at [www.covermymeds.health] or complete the entire form and fax to Novartis Patient Support at [800-414-3518]. Questions? Contact [866-433-8000]. An incomplete Start Form may delay the start of treatment.**

# Novartis Patient Support™

## KISQALI® (ribociclib) START FORM

* = REQUIRED

### 1. Please check the box that indicates the support your patient needs from Novartis Patient Support.

☐ **Electrocardiogram (ECG) Testing Support Only**

- Check this box and complete all highlighted fields below if you would like to enroll your patient in ECG testing support only (and no other services)

### 2. Patient Information

* First Name _____ * Last Name _____ * Phone Number _____ ☐ Mobile ☐ Home — *We'll keep you informed through non-marketing calls and texts.**

* Sex for Clinical Use: ☐ Male ☐ Female OK to Leave Voicemail for KISQALI: ☐ Yes ☐ No

* Date of Birth (MM/DD/YYYY) _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

* Address (No PO Box) _____

* City _____ * State _____ * ZIP _____ Email _____

I give permission to disclose my personal health information to the following Caregiver (optional):

Caregiver Name _____ Relationship to Patient _____ Caregiver Phone Number _____ ☐ Mobile ☐ Home — *We'll keep you informed through non-marketing calls and texts.**

### 3. Patient Authorization and Additional Enrollment Consents

I have read and agree to the Patient Authorization on page 4.

X _____

*** Patient/Authorized Representative Signature** *** Date (MM/DD/YYYY)**

☐ Check here if signed by an Authorized Representative.

**CO-PAY PLUS† FOR KISQALI**

Pay as little as $0

☐ I have read and agree to the Co-Pay Plus Terms and Conditions on page 4.

**GET ACCESS TO ONGOING SUPPORT**

☐ I'd like to sign up for access to ongoing support. I'll get KISQALI tips, resources, and reminders from Novartis Patient Support at the mobile phone number(s) I gave above.

By checking this box, I agree to receive recurring marketing calls and texts from and on behalf of Novartis Pharmaceuticals Corporation. These calls and texts may be automatic or recorded in advance. The number of calls and message frequency varies. My consent is not a condition of getting any goods or services from Novartis. I can opt out of the program at any time by calling [866-433-8000]. I can also text "STOP" to any Novartis Patient Support Ongoing Support message to opt out of texts or "HELP" for more information about this service. Message and data rates may apply.

### 4. Insurance Information

**Please include a copy (front and back) of the patient's insurance card(s) and/or complete the section below.**

**Check all that apply:** ☐ Patient Is the Policy Holder ☐ Patient Is Uninsured ☐ Image(s) of Insurance Card(s) Included

*** Pharmacy Insurance** ☐ Private ☐ Medicare Advantage ☐ Medicare Part D ☐ Medicaid ☐ Other: _____

*If separate from medical insurance.*

Insurance/Payer _____ Plan Name _____ Policy Phone Number _____

Member ID Number _____ Rx Group Number _____

PCN Number _____ BIN Number _____

**Primary Medical Insurance** ☐ Private ☐ Medicare Advantage ☐ Medicare A/B ☐ Medicaid ☐ Other: _____

Insurance/Payer _____ Plan Name _____ Policy Phone Number _____

Member ID Number _____ Group Number _____

**DO NOT FAX PATIENT MEDICAL RECORDS. ANY MEDICAL RECORDS SHARED WILL BE DESTROYED.**
**To report an adverse event, call [1-888-NOW-NOVA]**
**or visit www.novartis.com/report**

Sign up online at [www.covermymeds.health] or complete the entire form and fax to Novartis Patient Support at [800-414-3518]. Questions? Contact [866-433-8000]. An incomplete Start Form may delay the start of treatment.

**Novartis Patient Support**

# KISQALI® (ribociclib) START FORM

* = REQUIRED

* **Patient Name**

* **Date of Birth (MM/DD/YYYY)**

## 5. Prescriber Information

* First Name

* Last Name

PTAN Number

* Address

* Practice Name

* City

* State

* ZIP

* Practice Phone Number

* Prescriber NPI Number

Practice Contact Name

Tax ID Number

Practice Contact Phone Number

* Practice Fax

## 6. Additional Information

☐ HR+, HER2- Advanced or Metastatic Breast Cancer ☐ HR+, HER2- Stage II and III Early Breast Cancer

* **Primary Diagnosis Code:**

☐ _____

**Secondary Diagnosis Code:**

☐ _____

## 7. Electrocardiogram (ECG) Testing Support

If you are requesting ECG testing support, where will your patient complete their first ECG? ☐ In-home ☐ In-office ☐ ECG Support not needed

Do you need a portable ECG device provided to your office? ☐ Yes ☐ No

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# Novartis Patient Support

## KISQALI® (ribociclib) START FORM

* = REQUIRED

* **Patient Name** _____ * **Date of Birth (MM/DD/YYYY)** _____

## 8. Prescription Information

* **Preferred Specialty Pharmacy:**

☐ No preference: Please send the prescriptions to the patient's payer-mandated specialty pharmacy

☐ On-site dispense: Please send the prescription to our office for dispense _____ Phone Number _____ Fax Number

☐ Other (please fill out information below)

*Please note: A patient's health plan may dictate a specific specialty pharmacy.*

**Preferred Specialty Pharmacy: Please send the prescription to the specialty pharmacy listed below**

**Preferred Specialty Pharmacy** _____ **Preferred Specialty Pharmacy Phone Number** _____ **Preferred Specialty Pharmacy Fax** _____

* **Pharmacy Prescription:**

**Please check a single box in each applicable column.** For advanced or metastatic breast cancer, the recommended starting dose is 600 mg. For early breast cancer, the recommended starting dose is 400 mg. Please select the appropriate dose for your patient in the table below by checking a single box:

| Product Information | Dosage | Quantity | Refills ℞ |
|---|---|---|---|
| KISQALI<br>Tablet 200 mg | ☐ KISQALI 600 mg Dose Pack: 3 tablets per day<br>☐ KISQALI 400 mg Dose Pack: 2 tablets per day<br>☐ KISQALI 200 mg Dose Pack: 1 tablet per day | KISQALI packaging comes in 28-day cycle packs, which include a 21-day supply of tablets, followed by 7 days off. | ___ refills |

Dispense Notes _____

**The Bridge Program‡:** Eligible patients may receive KISQALI for free while pursuing insurance coverage via the Bridge Program. Eligible patients must have private insurance and a valid prescription for KISQALI and a prior authorization that has been required. Program requires the submission of an appeal of the coverage denial within the first 90 days of enrollment to remain eligible.

**Please check a single box in each applicable column.** For advanced or metastatic breast cancer, the recommended starting dose is 600 mg. For early breast cancer, the recommended starting dose is 400 mg. Please select the appropriate dose for your patient in the table below by checking a single box:

| Product Information | Dosage | Quantity | Refills ℞ |
|---|---|---|---|
| KISQALI<br>Tablet 200 mg | ☐ KISQALI 600 mg Dose Pack: 3 tablets per day<br>☐ KISQALI 400 mg Dose Pack: 2 tablets per day<br>☐ KISQALI 200 mg Dose Pack: 1 tablet per day | KISQALI packaging comes in 28-day cycle packs, which include a 21-day supply of tablets, followed by 7 days off. | ___ refills |

## Prescriber Attestation

I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the provider who has prescribed KISQALI 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 acknowledge that no medical records will be sent to Novartis Patient Support along with this Start Form. I have discussed the Novartis Patient Support Program 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 Novartis Patient Support. To complete this enrollment, Novartis may contact the patient by phone, text, and email.**

**X** _____

* **Prescriber Signature** **(Dispense as Written)** **(Substitution Permissible)** _____ * **Prescriber Name (Print Name)** _____ * **Date (MM/DD/YYYY)** _____

**ATTN:** Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).

**DO NOT FAX PATIENT MEDICAL RECORDS. ANY MEDICAL RECORDS SHARED WILL BE DESTROYED.**

**To report an adverse event, call [1-888-NOW-NOVA]**
**or visit www.novartis.com/report**

# Novartis Patient Support

**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 coordinate insurance coverage for, access to, and receipt of my medication.
- Communicate with me about possible financial assistance, including Novartis copay or NPAF programs, and, if I am enrolled, administer my participation in those programs.
- Communicate with me about my medication and treatment, including reminders, health and lifestyle tips, 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 I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling [866-433-8000] or by writing to:

Novartis Patient Support
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.

*Novartis Patient Support may call and text you at the numbers provided for non-marketing purposes (eg, to help you access and start on KISQALI). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling [866-433-8000].

**†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 (e.g., 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 (e.g., 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 (e.g., health plans, flexible spending or health care 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. For purchasers of FEMARA only, this is NOT valid for Massachusetts patients and is only valid for California patients that meet additional eligibility criteria.

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.

**‡The Bridge Program applies to KISQALI and the KISQALI FEMARA Co-Pack only.** Eligible patients must have private insurance, a valid prescription for KISQALI or the KISQALI FEMARA Co-Pack, and a denial of insurance coverage based on a prior authorization requirement. Program requires the submission of a prior authorization and/or appeal of the coverage denial within the first 90 days of enrollment to remain eligible. Program provides KISQALI for free to eligible patients for up to 5 months, or until they receive insurance coverage approval, whichever occurs earlier. A valid prescription consistent with FDA-approved labeling is required. Program is not available to patients whose medications are reimbursed in whole or in part by Medicare, Medicaid, TRICARE, or any other federal or state program. Patients may be asked to reverify insurance coverage status during the course of the program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Additional Limitations may apply. Novartis Pharmaceuticals Corporation reserves the right to rescind, revoke, or amend this Program without notice.

Please see full Novartis Pharmaceuticals Corporation Privacy Policy and the Mobile Terms of Use.

NOVARTIS

KISQALI® ribociclib 200 mg tablets