Novartis
Patient Support™

Guide to completing the **KISQALI® (ribociclib) Start Form**

Phone:
[866-433-8000]

Online:
[www.kisqali-startform.com]

Fax:
[800-414-3518]

For questions or support, reach out to your dedicated Associate Director, Access & Reimbursement (ADAR) or contact Novartis Patient Support.

KISQALI® ribociclib 200 mg tablets

Novartis Patient Support

Getting patients started

Novartis Patient Support will work with your practice to help your patient start on KISQALI® (ribociclib) tablets. Begin the process by completing the Start Form. We have outlined the key information below to help ensure a smoother process for your office and your patient.

All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

Please note that providers, along with their patients, can complete the Start Form online at the CoverMyMeds® portal or by faxing the completed Start Form to the number listed.

Look for this symbol ✱ as you fill out the Start Form. It indicates a required field.

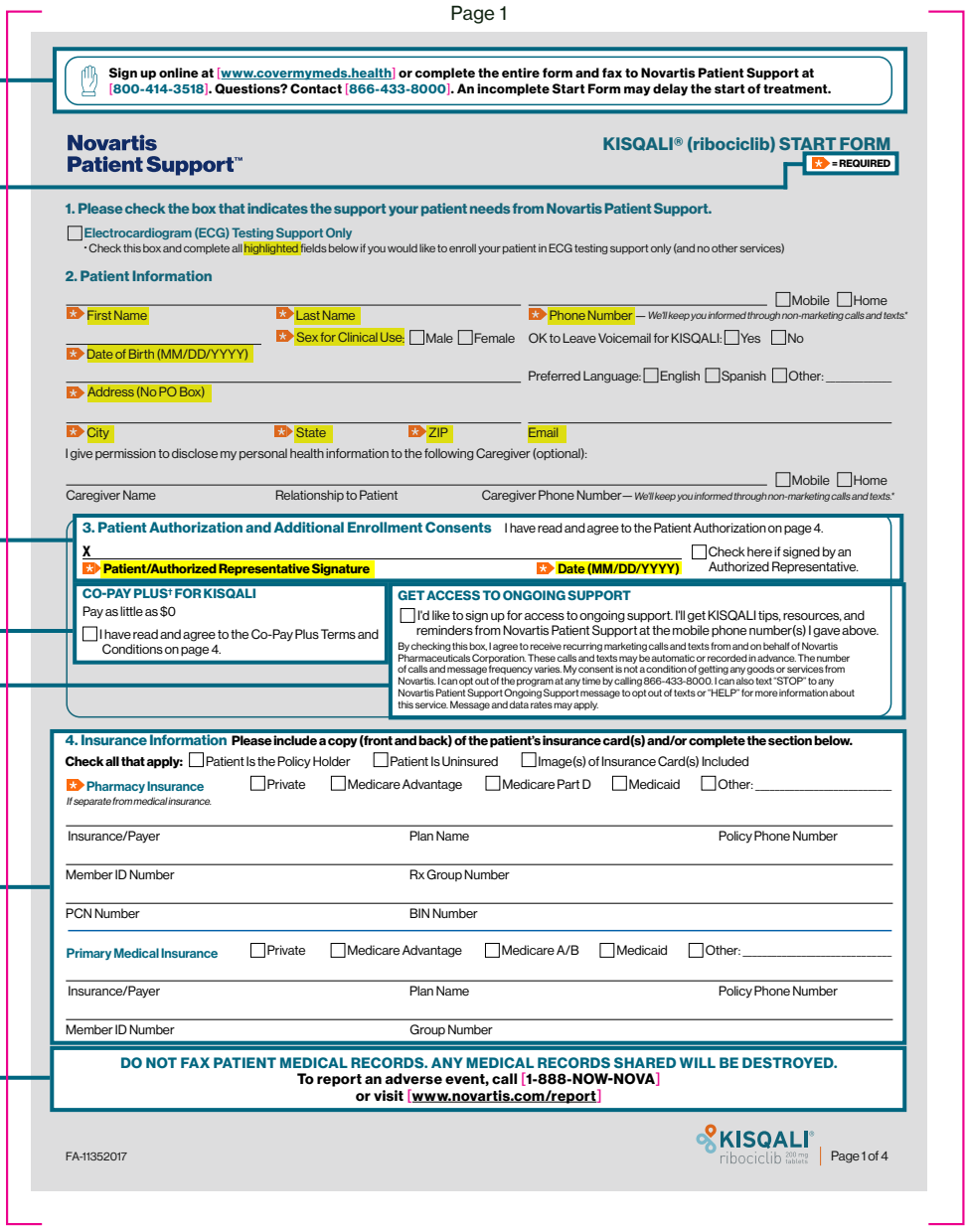
Get patient and/or authorized representative consent.

Patients can check this box to sign up for the Co-Pay Plus offer.

Patients can check this box to opt in to ongoing support.

Don't forget your patient's insurance information. We need to verify all their benefits.

Please **do not fax patient medical records**.



Page 1

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 — *We'll keep you informed through non-marketing calls and texts.** ☐ Mobile ☐ Home

✱ Date of Birth (MM/DD/YYYY) ✱ Sex for Clinical Use: ☐ Male ☐ Female OK to Leave Voicemail for KISQALI: ☐ Yes ☐ No

✱ Address (No PO Box) Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

✱ 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 — *We'll keep you informed through non-marketing calls and texts.** ☐ Mobile ☐ Home

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 *If separate from medical insurance.* ☐ Private ☐ Medicare Advantage ☐ Medicare Part D ☐ Medicaid ☐ Other: _____

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]

FA-11352017

KISQALI® ribociclib 200 mg tablets | Page 1 of 4

KISQALI® ribociclib 200 mg tablets

Novartis Patient Support

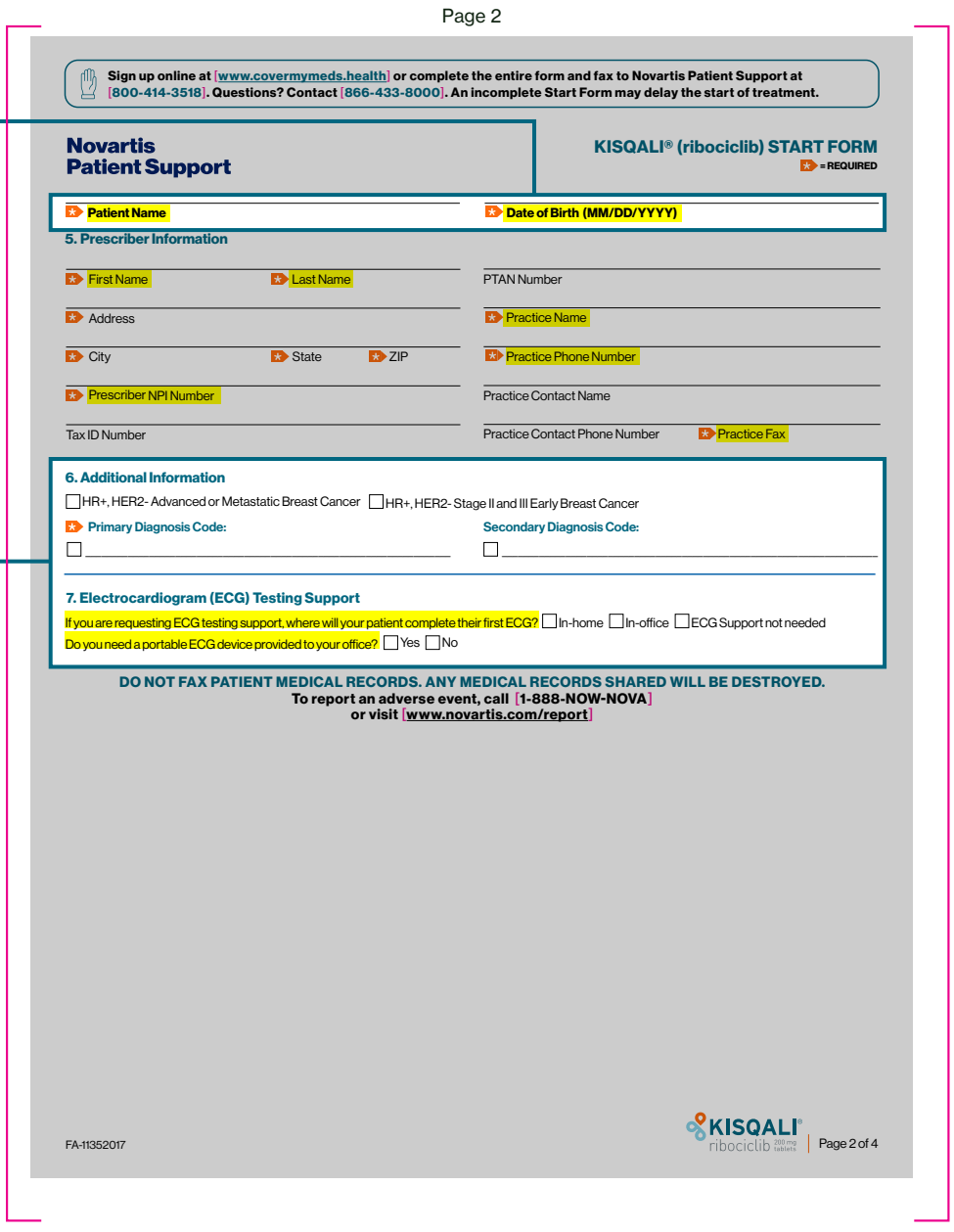
Getting patients started (cont)

All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

Make sure your patient's name and date of birth are present at the top of page 2.

It's important to review and capture all necessary information prior to initiating therapy:

- Check the appropriate box(es) for the treatment indication
- Indicate the applicable primary and secondary diagnosis code(s) for your patient here



Page 2

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

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]

FA-11352017

KISQALI® ribociclib 200 mg Tablets | Page 2 of 4

KISQALI® ribociclib 200 mg tablets

Novartis Patient Support

Getting patients started (cont)

All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

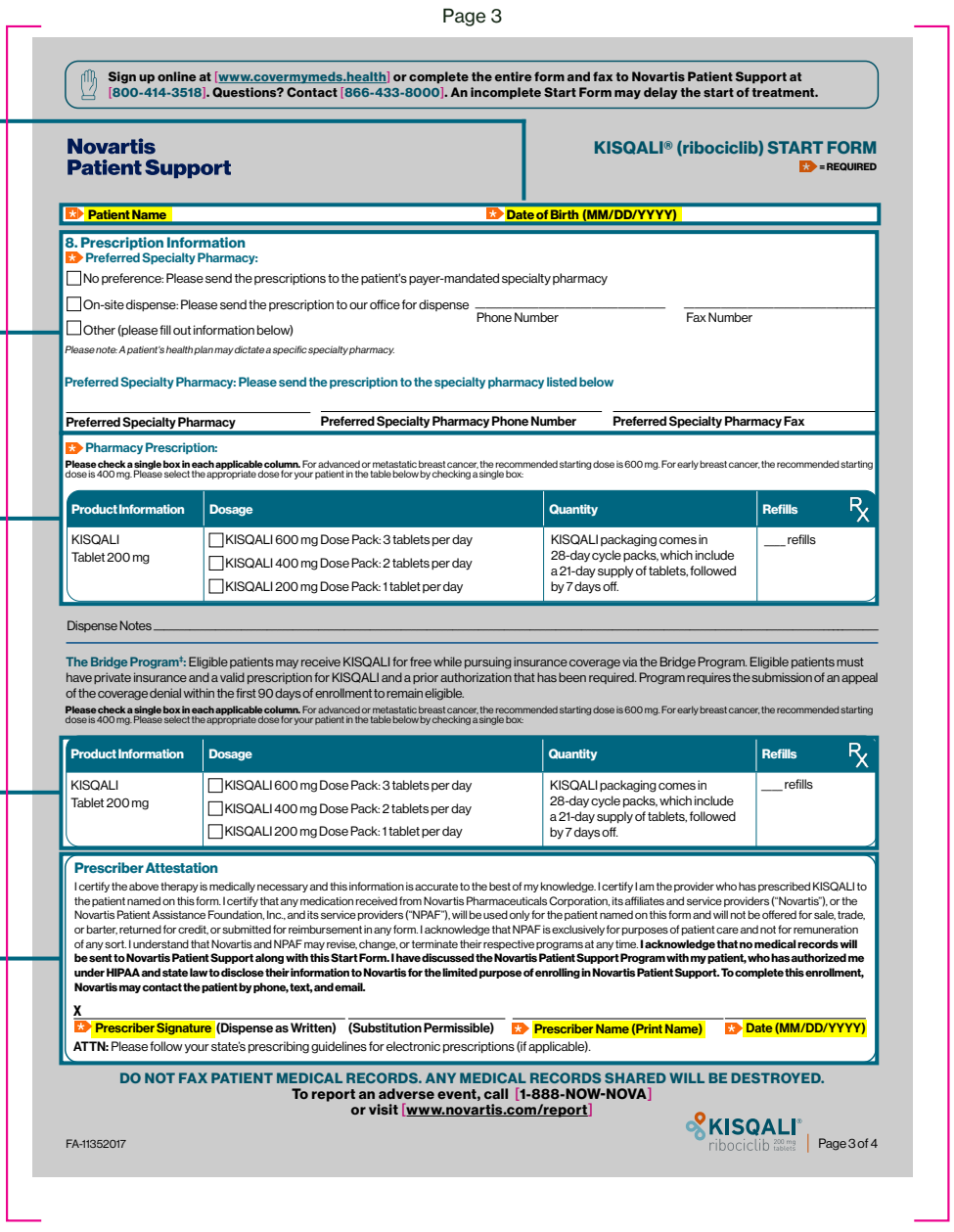
Make sure your patient's name and date of birth are present at the top of page 3.

Indicate your patient's Preferred Specialty Pharmacy.

Complete the Pharmacy Prescription table.

Complete the Bridge Program prescription table, so that your eligible patients can receive KISQALI for free while pursuing insurance coverage.

Please don't forget to sign and date the provider attestation.



Page 3

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)**

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 Tablet 200 mg	☐ 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	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[1]: 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 Tablet 200 mg	☐ 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	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]

FA-11352017

KISQALI® ribociclib 200 mg tablets | Page 3 of 4

KISQALI® ribociclib 200 mg tablets

Novartis Patient Support

Your patients are our top priority

Novartis Patient Support is a comprehensive program that is designed to help your eligible patients start, stay, and save on KISQALI.


Not actual patients.

We support you and your patient's journey with:

- Dedicated assistance with access and reimbursement
- Personalized support for your patients on therapy
- Single points of contact for you and your patients

Our offerings include:

Insurance Support

Help navigating the insurance process, including benefits verification and support with the prior authorization and appeals processes.

Financial Support

Assistance with relevant savings options for your eligible patients, including $0 Co-Pay Plus* offer and affordability programs.

Electrocardiogram (ECG) Testing Support

Guidance on workflow and options for testing.

Questions?

For more information, call Novartis Patient Support at [866-433-8000],
[Monday-Friday, 8:00 AM-8:00 PM ET, excluding holidays] or visit [**www.kisqali-hcp.com**]

*__Limitations apply.__ Subject to annual co-pay benefit limit. Offer not valid under Medicare, Medicaid, or any other federal or state programs. Novartis reserves the right to rescind, revoke, or amend this program without notice. Additional limitations may apply. See complete Terms & Conditions at [support.kisqali.com] for details.

The information herein is provided for educational purposes only. Novartis cannot guarantee health plan or reimbursement. Coverage and reimbursement may vary significantly by health plan, patient, and setting of care. It is the sole responsibility of the health care provider to select the proper codes and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient.

NOVARTIS

KISQALI® ribociclib 200 mg tablets

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

10/25

FA-11481276