Novartis
Patient Support™

Guide to completing the **SCEMBLIX® (asciminib) tablets Start Form**

Phone:
866-433-8000

Online:
www.scemblix-startform.com

Fax:
800-368-5564

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

Please see full Prescribing Information.

SCEMBLIX®
(asciminib) 20 mg, 40 mg tablets

Novartis Patient Support

Getting patients started

Novartis Patient Support will work with your practice to help your patient start on SCEMBLIX. 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.

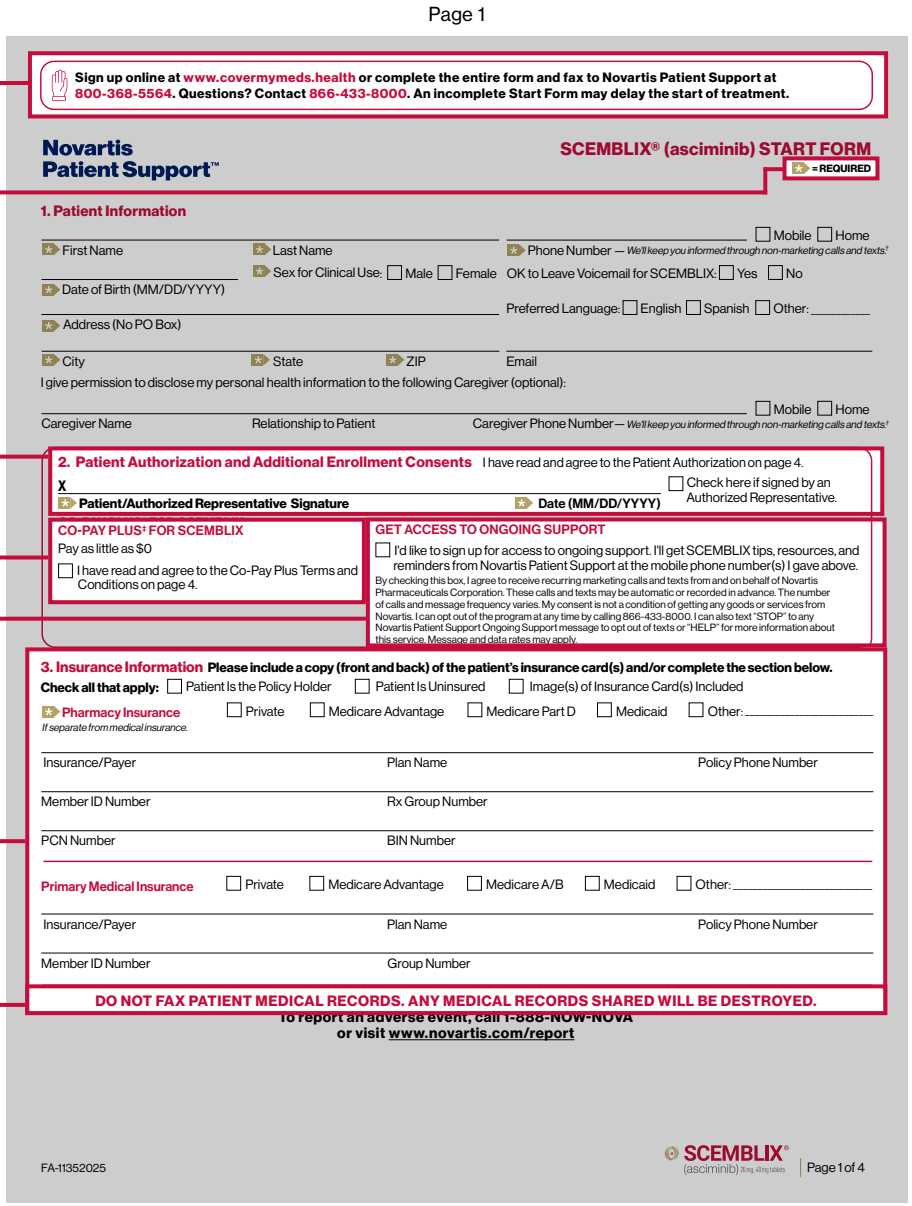
Get patient and/or authorized representative consent.

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 800-368-5564. Questions? Contact 866-433-8000. An incomplete Start Form may delay the start of treatment.

Novartis Patient Support™

SCEMBLIX® (asciminib) START FORM

★ = REQUIRED

1. 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 SCEMBLIX: ☐ 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

2. 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 SCEMBLIX

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 SCEMBLIX 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.

3. 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-11352025

SCEMBLIX® (asciminib) 20 mg, 40 mg tablets | Page 1 of 4

Please see full Prescribing Information.

SCEMBLIX® (asciminib) 20 mg, 40 mg tablets

Novartis
Patient Support

Getting patients started (cont)

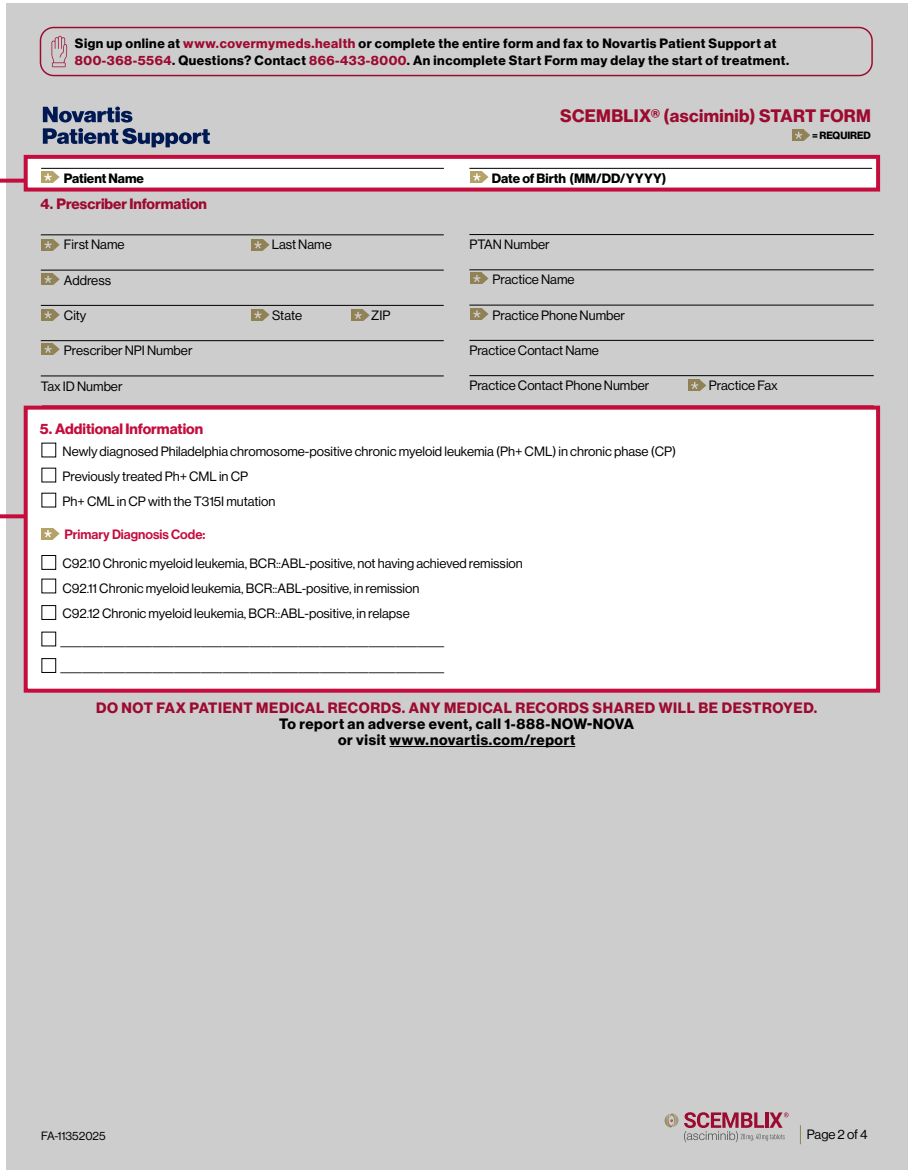
All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

Page 2

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:

- Indicate the applicable primary diagnosis code(s) for your patient here



Sign up online at www.covermymeds.health or complete the entire form and fax to Novartis Patient Support at 800-368-5564. Questions? Contact 866-433-8000. An incomplete Start Form may delay the start of treatment.

Novartis Patient Support

SCEMBLIX® (asciminib) START FORM

* = REQUIRED

* Patient Name

* Date of Birth (MM/DD/YYYY)

4. 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

5. Additional Information

☐ Newly diagnosed Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP)

☐ Previously treated Ph+ CML in CP

☐ Ph+ CML in CP with the T315I mutation

* Primary Diagnosis Code:

☐ C92.10 Chronic myeloid leukemia, BCR::ABL-positive, not having achieved remission

☐ C92.11 Chronic myeloid leukemia, BCR::ABL-positive, in remission

☐ C92.12 Chronic myeloid leukemia, BCR::ABL-positive, in relapse

☐ _____

☐ _____

DO NOT FAX PATIENT MEDICAL RECORDS. ANY MEDICAL RECORDS SHARED WILL BE DESTROYED.
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or visit www.novartis.com/report

FA-11352025

SCEMBLIX® (asciminib) 20 mg, 40 mg tablets | Page 2 of 4

Please see full Prescribing Information.

SCEMBLIX®
(asciminib) 20 mg, 40 mg tablets

Novartis Patient Support

Getting patients started (cont)

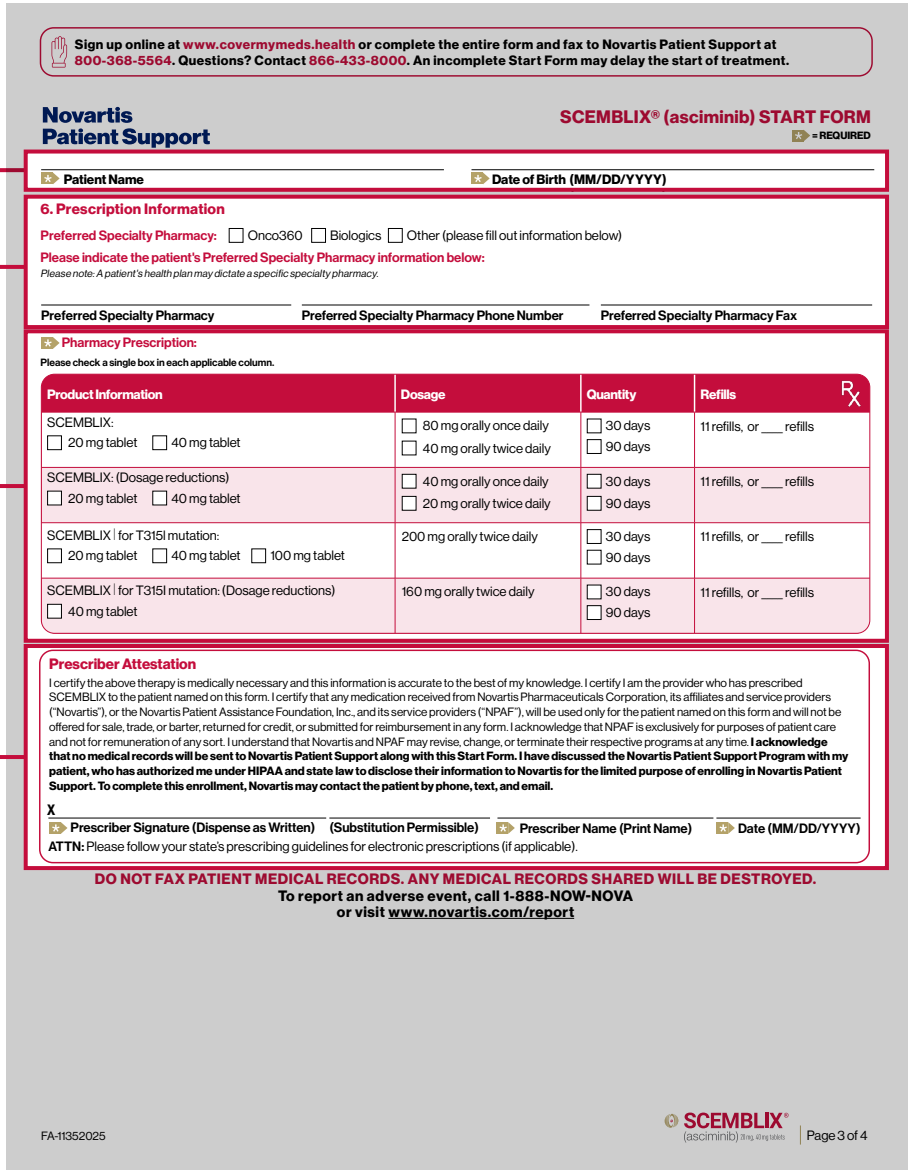
All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

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

Indicate your patient's Specialty Pharmacy.

Complete the Pharmacy Prescription table.

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 800-368-5564. Questions? Contact 866-433-8000. An incomplete Start Form may delay the start of treatment.

Novartis Patient Support

SCEMBLIX® (asciminib) START FORM

* = REQUIRED

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

6. Prescription Information

Preferred Specialty Pharmacy: ☐ Onco360 ☐ Biologics ☐ Other (please fill out information below)

Please indicate the patient's Preferred Specialty Pharmacy information below:

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

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

* Pharmacy Prescription:

Please check a single box in each applicable column.

Product Information	Dosage	Quantity	Refills Rx
SCEMBLIX: ☐ 20 mg tablet ☐ 40 mg tablet	☐ 80 mg orally once daily ☐ 40 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX: (Dosage reductions) ☐ 20 mg tablet ☐ 40 mg tablet	☐ 40 mg orally once daily ☐ 20 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX	for T315I mutation: ☐ 20 mg tablet ☐ 40 mg tablet ☐ 100 mg tablet	200 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX	for T315I mutation: (Dosage reductions) ☐ 40 mg tablet	160 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ 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 SCEMBLIX 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-11352025

SCEMBLIX® (asciminib) 20 mg, 40 mg tablets | Page 3 of 4

Please see full Prescribing Information.

SCEMBLIX® (asciminib) 20 mg, 40 mg tablets

Novartis
Patient Support

INDICATIONS and IMPORTANT SAFETY INFORMATION

INDICATIONS

SCEMBLIX® (asciminib) tablets is indicated for the treatment of adult patients with:

- Newly diagnosed Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP)
  - This indication is approved under accelerated approval based on major molecular response rate. Continued approval for this indication may be contingent upon verification of clinical benefit in a confirmatory trial(s)
- Previously treated Ph+ CML in CP
- Ph+ CML in CP with the T315I mutation

IMPORTANT SAFETY INFORMATION

Myelosuppression

- Thrombocytopenia, neutropenia, and anemia, including grade 3/4 reactions, have occurred in patients receiving SCEMBLIX
- Perform complete blood counts every 2 weeks for the first 3 months of treatment and monthly thereafter or as clinically indicated. Monitor patients for signs and symptoms of myelosuppression
- Based on the severity of thrombocytopenia and/or neutropenia, reduce dose, temporarily withhold, or permanently discontinue SCEMBLIX as described in the prescribing information

Pancreatic Toxicity

- Pancreatitis (including grade 3 reactions) and elevation in serum lipase and amylase (including grade 3/4 elevations), have occurred in patients receiving SCEMBLIX
- Assess serum lipase and amylase levels monthly during treatment with SCEMBLIX, or as clinically indicated. Monitor patients for signs and symptoms of pancreatic toxicity. Perform more frequent monitoring in patients with a history of pancreatitis
- If lipase and amylase elevation are accompanied by abdominal symptoms, temporarily withhold SCEMBLIX and consider appropriate diagnostic tests to exclude pancreatitis
- Based on the severity of lipase and amylase elevation, reduce dose, temporarily withhold, or permanently discontinue SCEMBLIX as described in the prescribing information

Hypertension

- Hypertension, including grade 3/4 reactions, have occurred in patients receiving SCEMBLIX
- Monitor and manage hypertension using standard antihypertensive therapy during treatment with SCEMBLIX as clinically indicated
- For grade 3 or higher reactions, temporarily withhold, reduce dose, or permanently discontinue SCEMBLIX as described in the prescribing information depending on persistence of hypertension

Hypersensitivity

- Hypersensitivity, including grade 3/4 reactions, have occurred in patients receiving SCEMBLIX. Reactions included rash, edema, and bronchospasm
- Monitor patients for signs and symptoms and initiate appropriate treatment as clinically indicated
- For grade 3 or higher reactions, temporarily withhold, reduce dose, or permanently discontinue SCEMBLIX as described in the prescribing information depending on persistence of hypersensitivity

Please see full Prescribing Information.

SCEMBLIX®
(asciminib) 20 mg, 40 mg tablets

Novartis
Patient Support

INDICATIONS and IMPORTANT SAFETY INFORMATION (cont)

IMPORTANT SAFETY INFORMATION (cont)

Cardiovascular Toxicity

- Cardiovascular toxicity (including ischemic cardiac and central nervous system conditions; and arterial thrombotic and embolic conditions) and cardiac failure have occurred in patients receiving SCEMBLIX. Some toxicities were grade 3/4 and 5 fatalities were reported
- Arrhythmia, including QTc prolongation, have occurred in patients receiving SCEMBLIX. Some of these arrhythmias were grade 3/4
- Monitor patients with a history of cardiovascular risk factors for cardiovascular signs and symptoms. Initiate appropriate treatment as clinically indicated
- For grade 3 or higher cardiovascular toxicity, temporarily withhold, reduce dose, or permanently discontinue SCEMBLIX as described in the prescribing information depending on persistence of cardiovascular toxicity

Embryo-Fetal Toxicity

- SCEMBLIX can cause fetal harm. Advise females of reproductive potential of the potential risk to a fetus if SCEMBLIX is used during pregnancy or if the patient becomes pregnant while taking SCEMBLIX
- Verify the pregnancy status of females of reproductive potential prior to starting treatment with SCEMBLIX. Advise females to use effective contraception during treatment and for at least 1 week after the last SCEMBLIX dose

ADVERSE REACTIONS

- Most common adverse reactions (≥20%) were musculoskeletal pain, rash, fatigue, upper respiratory tract infection, headache, abdominal pain, arthralgia, and diarrhea
- Most common select laboratory abnormalities (≥20%) were lymphocyte count decreased, leukocyte count decreased, platelet count decreased, neutrophil count decreased, calcium corrected decreased, lipase increased, cholesterol increased, uric acid increased, alanine aminotransferase increased, alkaline phosphatase increased, hemoglobin decreased, triglycerides increased, creatine kinase increased, amylase increased, and aspartate aminotransferase increased

DRUG INTERACTIONS

- Asciminib is an inhibitor of CYP3A4, CYP2C9, P-gp, and BCRP. Asciminib is a CYP3A4 substrate
- Closely monitor for adverse reactions during concomitant use of strong CYP3A4 inhibitors and SCEMBLIX at 200 mg twice daily
- Avoid concomitant use of itraconazole oral solution containing hydroxypropyl-β-cyclodextrin and SCEMBLIX at all recommended doses
- Closely monitor for adverse reactions during concomitant use of certain CYP3A4 substrates and SCEMBLIX at 80 mg total daily dose. Avoid use of SCEMBLIX at 200 mg twice daily
- Avoid concomitant use of CYP2C9 substrates and SCEMBLIX at all recommended doses. If coadministration with 80 mg total daily dose is unavoidable, reduce the CYP2C9 substrate dosage as recommended in its prescribing information. If coadministration with 200 mg twice daily is unavoidable, consider alternative therapy with a non-CYP2C9 substrate
- Closely monitor for adverse reactions during concomitant use of certain P-gp substrates and SCEMBLIX at all recommended doses
- Avoid concomitant use of rosuvastatin and SCEMBLIX at all recommended doses. Closely monitor for adverse reactions during concomitant use of other BCRP substrates and SCEMBLIX at all recommended doses

Please see full Prescribing Information.

SCEMBLIX®
(asciminib) 20 mg, 40 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 SCEMBLIX.

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.

Ongoing Support

Dedicated assistance from our team and educational resources to help your patients get started on treatment and guide them along the way.

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 **scemblix-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.scemblix.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.

Please see full Prescribing Information.

NOVARTIS

SCEMBLIX® (asciminib) 20 mg, 40 mg tablets

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

10/25

FA-11484182

Sign up online at www.covermymeds.health or complete the entire form and fax to Novartis Patient Support at 800-368-5564. Questions? Contact 866-433-8000. An incomplete Start Form may delay the start of treatment.

Novartis Patient Support™

SCEMBLIX® (asciminib) START FORM

* = REQUIRED

1. 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 SCEMBLIX: ☐ 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

2. Patient Authorization and Additional Enrollment Consents

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

X _____ ☐ Check here if signed by an Authorized Representative.

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

CO-PAY PLUS‡ FOR SCEMBLIX

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 SCEMBLIX 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.

3. 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.

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Novartis Patient Support

SCEMBLIX® (asciminib) START FORM

* = REQUIRED

* **Patient Name**

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

4. 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

5. Additional Information

- ☐ Newly diagnosed Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP)
- ☐ Previously treated Ph+ CML in CP
- ☐ Ph+ CML in CP with the T315I mutation

* **Primary Diagnosis Code:**

- ☐ C92.10 Chronic myeloid leukemia, BCR::ABL-positive, not having achieved remission
- ☐ C92.11 Chronic myeloid leukemia, BCR::ABL-positive, in remission
- ☐ C92.12 Chronic myeloid leukemia, BCR::ABL-positive, in relapse
- ☐ _____
- ☐ _____

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Novartis Patient Support

SCEMBLIX® (asciminib) START FORM

* = REQUIRED

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

6. Prescription Information

Preferred Specialty Pharmacy: ☐ Onco360 ☐ Biologics ☐ Other (please fill out information below)

Please indicate the patient's Preferred Specialty Pharmacy information below:

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

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

* **Pharmacy Prescription:**

Please check a single box in each applicable column.

Product Information	Dosage	Quantity	Refills Rx
SCEMBLIX: ☐ 20 mg tablet ☐ 40 mg tablet	☐ 80 mg orally once daily ☐ 40 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX: (Dosage reductions) ☐ 20 mg tablet ☐ 40 mg tablet	☐ 40 mg orally once daily ☐ 20 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX	for T315I mutation: ☐ 20 mg tablet ☐ 40 mg tablet ☐ 100 mg tablet	200 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX	for T315I mutation: (Dosage reductions) ☐ 40 mg tablet	160 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ 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 SCEMBLIX 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 SCEMBLIX). 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.

‡**Limitations apply.** Valid only for those with private insurance. The Program includes the Co-Pay Plus offer, Plus Card (if applicable), and Rebate, with a combined annual limit. Patient is responsible for any costs once limit is reached in a calendar year. Program not valid (i) under Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program, (ii) where patient is not using insurance coverage at all, (iii) where the patient's insurance plan reimburses for the entire cost of the drug, or (iv) where product is not covered by patient's insurance. The value of this program is exclusively for the benefit of patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles. Program is not valid where prohibited by law. Patient may not seek reimbursement for the value received from this program from other parties, including any health insurance program or plan, flexible spending account, or health care savings account. Patient is responsible for complying with any applicable limitations and requirements of their health plan related to the use of the Program. Valid only in the United States and Puerto Rico. This Program is not health insurance. Program may not be combined with any third-party rebate, coupon, or offer. Proof of purchase may be required. Novartis reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

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SCEMBLIX® (asciminib) 20 mg, 40 mg tablets