ILARIS START FORM

ILARIS® (canakinumab) 150 mg subcutaneous injection

IlarisSupportProgram@ubc.com | 1-866-972-8315 | 1-866-972-8316

1 PATIENT INFORMATION

Patient's Last Name | First Name | Middle Name

Caregiver Name | Caregiver Relationship to Patient | Birth Date | Weight | Sex: ☐ M ☐ F

City | State | ZIP Code | Street Address

Email* | Home Phone | Cell Phone*

Contact me by (optional): ☐ Cell Phone ☐ Home Phone ☐ Email **Best time to call (optional):** ☐ Morning ☐ Afternoon ☐ Evening

Preferred language (optional): ☐ English ☐ Spanish ☐ Other: _____ **Okay to leave message?** ☐ Yes ☐ No

***For patients under 18 years of age, please provide parent's or caregiver's email and cell phone information.**

PATIENT AUTHORIZATION (REQUIRED)

I confirm the information provided herein is truthful and accurate to the best of my knowledge.
I have read and agree to the required Patient Authorization detailed on page 3 to enroll into ILARIS Companion.

PATIENT/LEGAL GUARDIAN SIGNATURE | **Date of Signature (MM/DD/YYYY)**

Patients may also provide consent electronically at www.hipaaconsent.com

CANNOT PROCESS THIS FORM WITHOUT PATIENT CONSENT

ILARIS Companion Optional Support Services

☐ **I have read and agree to the Telephone Consumer Protection Act (TCPA) Consent on page 3.**

ILARIS Co-pay Program (checkbox required if requested)

☐ **I have read and agree to the ILARIS Co-Pay Program Terms and Conditions on Page 4. I direct the ILARIS Co-Pay Program to make co-pay benefit payments on my behalf directly to my health care providers for qualifying claims.**

2 INSURANCE INFORMATION – Include copy of the insurance card(s) (front and back) and complete all the information below

Beneficiary/Cardholder Name | Prescription Insurance Name

Medical Insurance Name | Medical Insurance Phone | Prescription Insurance ID #

Medical Insurance ID # | Group # | Group # | BIN | PCN

ADDITIONAL SUPPORT SERVICES/INFORMATION

If required, has a prior authorization been submitted? ☐ Yes ☐ No

Does patient already have co-pay card? ☐ Yes ☐ No

No services requested/Benefits Investigation only? ☐ Yes ☐ No

Will office buy and bill ILARIS? ☐ Yes ☐ No

3 PRESCRIBER INFORMATION

Prescriber Name | NPI # | Tax ID #

Practice Name/Office Location | Phone | Fax

Address | Primary Office Contact/Name

City | State | ZIP Code | Email

Please continue to Section 4 on page 2

Patient's Last Name | First Name | Birth Date

4 PRESCRIPTION INFORMATION (REQUIRED)

Rx: ILARIS® (canakinumab) Injection 150-mg/mL 1-mL vial solution
10-digit NDC: 0078-0734-61

For M08.2, M08.9, and M10.0-M10.4, be sure to specify anatomical site followed by another number to specify laterality of the site affected.

Primary Diagnosis/ICD-10-CM Codes (check one)

- ☐ M04.2 CAPS (includes FCAS and MWS)
- ☐ M04.1 FMF, HIDS/MKD, and TRAPS
- ☐ M06.1 Adult-onset Still's disease
- ☐ M08.2 _____ Juvenile rheumatoid arthritis with systemic onset (Still's disease NOS)
- ☐ M08.9 _____ Juvenile arthritis, unspecified
- ☐ M10. _____ Gout flares: Insert appropriate code* and site, if applicable
- ☐ Other ICD-10-CM Code(s): _____

Dose (mg): _____ **Patient's body weight:** _____

Quantity of vial(s) for 150-mg/mL ILARIS (includes supplies): _____

Supplies per vial include (one each)†:

- 1-mL syringe
- 27 G x 0.5" (13 mm) needle for administration
- 18 G x 2" (50 mm) needle for medication withdrawal

Administer subcutaneously every: _____ **Weeks** **# of Refills:** _____

Has a prescription been sent to a Specialty Pharmacy?

☐ Yes Specialty Pharmacy name: _____ ☐ No

*0=Idiopathic gout; 1=Lead-induced gout; 2=Drug-induced gout; 3=Gout due to renal impairment; 4=Other secondary gout; 9=Gout, unspecified.
†Please note that an additional prescription may be needed based on state-specific pharmacy laws.

For reference only: do not write in this box

CAPS: Recommended weight-based dosage for patients >40 kg is 150 mg subcutaneously, every 8 weeks. For patients ≥15 kg and ≤40 kg: 2 mg/kg subcutaneously, every 8 weeks.

For pediatric patients 15 kg to 40 kg with an inadequate response, the dose can be increased to 3 mg/kg subcutaneously, every 8 weeks.

FMF, HIDS/MKD, TRAPS: Recommended weight-based dosage for patients >40 kg is 150 mg subcutaneously, every 4 weeks. Dosage can be increased to 300 mg every 4 weeks if clinical response is not adequate.

For patients ≤40 kg, starting dosage is 2 mg/kg subcutaneously, every 4 weeks. Dosage can be increased to 4 mg/kg every 4 weeks if clinical response is not adequate.

Still's disease (AOSD and SJIA): Recommended weight-based dosage for patients ≥7.5 kg is 4 mg/kg (with a maximum dose of 300 mg) subcutaneously, every 4 weeks.

Gout flares: Recommended dosage is 150 mg administered subcutaneously. In patients who require re-treatment, there should be an interval of at least 12 weeks before a new dose of ILARIS may be administered.

5 SUPPORT SERVICES‡ (OPTIONAL)

Home Health Nurse Service:
Physicians can request a nurse to administer ILARIS at a patient's home free of charge.

☐ Yes, I am interested in home health nurse service for my patient.

‡Limitations apply. Please contact ILARIS Companion at 1-866-972-8315 for more information.

PRESCRIBER CERTIFICATION

I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed ILARIS to the previously identified patient. I have discussed ILARIS Companion 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 ILARIS Companion. To complete this enrollment, Novartis may contact the patient by phone, text, and/or email. I agree to the NPAF Authorization on page 4. I also agree to receive communications, including faxes, related to my patient's enrollment or participation in ILARIS Companion. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. I authorize Novartis Pharmaceuticals Corporation and its service providers and the Novartis Patient Assistance Foundation Inc., and its service providers to transmit the above prescription by any means allowed under applicable law to the appropriate specialty pharmacy for my patient.

PLEASE SIGN HERE (REQUIRED)

Prescriber Signature for Substitution Permissible | **Date of Signature (MM/DD/YYYY)**

Prescriber Signature for Dispense as Written (DAW) | **Date of Signature (MM/DD/YYYY)**

CANNOT PROCESS FORM WITHOUT THIS COMPLETED.
ATTN: Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).

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Please read the following carefully, then sign and date where indicated on page 1.

PATIENT AUTHORIZATION

I give permission for my health care providers (HCPs), pharmacies, service providers, and their contractors ("Health Care Providers"), health insurer(s) and their contractors ("Insurers"), and third-party contractors, to disclose my personal information, including information about my insurance benefits, prescriptions, my medical condition and history, adherence to my treatment, and my general health ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates, business partners, and agents, ("Novartis") and the Novartis Patient Assistance Foundation, Inc. ("NPAF") (collectively, "the Companies") so that the Companies may: (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with ILARIS® (canakinumab), (ii) coordinate my receipt of and payment for ILARIS, (iii) facilitate my access to ILARIS, (iv) provide me with information about Novartis products, disease education and management programs, and promotional materials, (v) if I am eligible, coordinate the ILARIS Co-pay Program, including managing and communicating with me about the co-pay support options available to me, (vi) provide me with medication reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with ILARIS Companion and other related programs, and (viii) if I am eligible to apply to programs offered by NPAF, administer those programs, send me information about programs that might help me pay for medicines, and coordinate or share my Personal Information with my Health Care Providers, other programs that might help me pay for medicines, government agencies, and insurance companies for purposes of providing or facilitating this assistance.

I give permission to the Companies to disclose my Personal Information to my Health Care Providers, insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above. I also give permission to the Companies to combine or aggregate any information collected from me with information the Companies may collect about me from other sources for the purpose of providing or administering Program services.

I understand that some of my pharmacies or other Health Care Providers may receive payment from the Companies depending on my enrollment or participation in therapy support services such as prescription refill reminders. I understand that once my Personal Information is disclosed, it may no longer be protected by federal privacy law and applicable state laws. Even though HIPAA may no longer apply, the Companies safeguard patient data through reasonable security measures and will use and share it only for the purposes specified in this Authorization.

I understand that I may refuse to sign this Authorization. I also may revoke (cancel) or get a copy of this Authorization at any time by calling 1-866-972-8315 or by writing to the Customer Interaction Center, Novartis Pharmaceuticals Corporation, One Health Plaza, East Hanover, NJ 07936-1080. If I cancel my consent, I will no longer qualify for the services described. I also understand that some of my pharmacies or other Health Care Providers may receive payment from the Companies for disclosing my Personal Information as outlined in this Authorization and for therapy support services depending on my enrollment or participation in therapy support services such as prescription refill reminders.

My refusal or future revocation will not affect my medical treatment or insurance benefits; however, if I revoke this authorization, I may no longer be able to participate in ILARIS Companion and related programs. If I revoke this Authorization, the Companies will stop using or sharing my information (except as necessary to end my participation in the program), but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this Authorization. I understand that this authorization will remain valid for 5 years after the date of my signature, unless a shorter period is required by applicable state law or I revoke it earlier. I also understand that ILARIS Companion may change or end at any time without prior notification. I understand that I am entitled to receive a copy of this Patient Authorization.

I agree to be contacted by mail, email, telephone calls, and text messages at the numbers and addresses provided on this Form for all purposes described in this Patient Authorization. I also agree to be contacted by the Companies and others on its behalf by telephone calls and text messages made by or using automatic telephone dialing machines or artificial or prerecorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys.

I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to notify the Companies promptly if any of my number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that the Companies do not permit my Personal Information to be used by their business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by email and cell phone cannot be secured against unauthorized access.

TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT (OPTIONAL)

Telephone Consumer Protection Act (TCPA) Consent (Optional): I consent to receive marketing calls and texts from and on behalf of Novartis Pharmaceuticals Corporation, made with an auto dialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required as a condition of purchase. I agree to the TCPA Terms & Conditions. Number of messages will vary based on my program selections. Message and data rates may apply. I understand that I can read the full Novartis Pharmaceuticals Corporation Privacy Policy at www.usprivacy.novartis.com. Text STOP to opt out and HELP for help.

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TELEPHONE CONSUMER PROTECTION ACT (TCPA) TERMS AND CONDITIONS

By signing up to receive marketing texts and calls, or by requesting information by telephone, text message, fax, email, direct mail, or other means, you accept, without limitation or qualification, that:

- You and Novartis agree that any legal disputes or claims arising out of or related to these TCPA Terms and Conditions, or the use of the Novartis products and/or the Services (including but not limited to telephone calls or text messages sent by Novartis), or the interpretation, enforceability, revocability, or validity of these TCPA Terms and Conditions, or the arbitrability of any dispute that cannot be resolved informally shall be submitted to binding arbitration in the State of New York. The arbitration shall be conducted by the American Arbitration Association under its Commercial Arbitration Rules.
- This arbitration clause is an independent agreement and shall survive the termination and/or transfer of these TCPA Terms and Conditions or any other agreement between you and Novartis. If any provision of the agreement to arbitrate in this Section is found unenforceable, the unenforceable provision will be severed and the remaining arbitration terms will be enforced (but in no case will there be a class, representative, or private attorney general arbitration). Any judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Claims shall be brought within the time required by applicable law. The laws of the State of New York will govern these TCPA Terms and Conditions, and the Federal Arbitration Act, 9 U.S.C. §§ 1-16, will govern this Section, without giving effect to any principles of conflicts of laws. Each party shall bear its own costs relating to the arbitration consistent with the Commercial Arbitration Rules of the American Arbitration Association.
- You and Novartis agree that any claim, action, or proceeding arising out of or related to these TCPA Terms and Conditions, or the use of the Novartis products and/or the Services (including but not limited to telephone calls or text messages sent by Novartis) must be brought in your individual capacity, and not as a plaintiff or class member in any purported class, collective, or representative proceeding. The arbitrator may not consolidate more than one person's claims, and the arbitrator may not otherwise preside over any form of a representative, collective, or class proceeding.

YOU ACKNOWLEDGE AND AGREE THAT YOU AND NOVARTIS ARE EACH WAIVING THE RIGHT TO A TRIAL BY JURY OR TO PARTICIPATE AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS ACTION OR REPRESENTATIVE PROCEEDING.

CO-PAY ASSISTANCE PROGRAM TERMS AND CONDITIONS

Program Terms & Conditions

Limitations apply. Valid only for those with private insurance. The Program includes the Co-pay Card, Payment Card (if applicable), and Rebate, with a combined annual limit of $36,000. 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.

PRESCRIBER AUTHORIZATION FOR THE NOVARTIS PATIENT ASSISTANCE FOUNDATION, INC. (NPAF)

I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Further, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that NPAF may revise, change, or terminate programs at any time.

All sections of this form must be completed by the physician, patient, and/or appropriate office staff member only.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

10/25 FA-11507541