ILARIS FREE TRIAL OFFER FORM

ILARIS (canakinumab) 150 mg subcutaneous injection

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

This form is required to provide a prescription for patients to receive an ILARIS® (canakinumab) Free Trial Offer (FTO). By completing and submitting this form, you agree to the following terms and conditions:

No purchase required. Eligible patients must be new to therapy. Eligible patients may not receive more than one dose under the program. The free trial offer is not health insurance. Void where prohibited by law. Product dispensed pursuant to terms and conditions of the FTO program. Valid only in the United States and Puerto Rico. Claims shall not be submitted to any public or private third-party payer or any federal or state health care program for reimbursement. It is illegal for any person to sell, purchase, or trade, or offer to sell, purchase or trade, or to counterfeit the FTO request form. This is the property of Novartis Pharmaceuticals Corporation and must be returned upon request. Novartis Pharmaceuticals Corporation reserves the right to rescind, revoke, or amend the offer without notice.

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 Free Trial Offer.

_____ _____

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

2 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 3 on page 2

Patient's Last Name _____ First Name _____ Birth Date _____

3 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

Refill(s) Authorized: 0

*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.

4 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 the above therapy is medically necessary, and this information is accurate to the best of my knowledge. I certify that I am the provider who has prescribed ILARIS® (canakinumab) to the previously identified patient. I understand that I am receiving this product free of charge and that no claims for the free goods or related services are intended to be submitted to any public or private third-party payer or any health care program for reimbursement. I further understand these free goods are intended only for the patient named on this form and will not be offered for sale, trade, or barter.

PLEASE SIGN HERE (REQUIRED)

Prescriber Signature _____ **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"), and third-party contractors, to disclose my personal information, including information about my 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") (collectively, "the Companies") so that the Companies may: (i) facilitate my access to ILARIS, (ii) provide me with information about Novartis products, disease education and management programs, and promotional materials, and (iii) conduct quality assurance, surveys, and other internal business activities in connection with ILARIS Free Trial Offer and other related programs.

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 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.

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 Free Trial Offer 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 Free Trial Offer 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.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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