Sign up online at www.covermymeds.health. Or complete entire form and fax to Novartis Patient Support at 844-666-1366 or 800-343-9117. Questions? Contact 844-267-3689. An incomplete Start Form may delay the start of treatment.

Novartis Patient Support™

COSENTYX® (secukinumab) EMA START FORM

* = REQUIRED

Subcutaneous use — includes:
Coverage, Prior Authorization, and Appeals Support:
Support from the initial benefits verification through prior authorization and appeals

1. Patient Information

For patients under 18 years of age, please provide parent or authorized representative's email and phone number.

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

* Date of Birth (MM/DD/YYYY) _____ * Sex for Clinical Use: ☐ Male ☐ Female OK to Leave Voicemail for COSENTYX: ☐ 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 _____ ☐ Mobile ☐ Home — *We'll keep you informed through non-marketing calls and texts.†*

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 COSENTYX

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 COSENTYX 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 844-267-3689. 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.
To report an adverse event, call 1-888-NOW-NOVA or visit www.novartis.com/report

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* = REQUIRED

* **Patient Name**

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

4. Prescriber Information

* First Name

* Last Name

* Practice Name

* Address

* Practice Phone Number

* City

* State

* ZIP

Practice Contact Name

* Prescriber NPI Number

Practice Contact Phone Number

* Practice Fax

Tax ID Number

5. Additional Information

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

☐ L40.0 Plaque Psoriasis ☐ L40.5 Psoriatic Arthritis ☐ L40.54 Psoriatic Juvenile Arthropathy ☐ L73.2 Hidradenitis Suppurativa

☐ M08.90 Juvenile Arthritis, unspecified ☐ M45.0 Ankylosing Spondylitis ☐ M45.A Non-Radiographic Axial Spondyloarthritis

Secondary Diagnosis/Special Areas or Manifestations (optional): _____

Excluding COSENTYX, does this patient have a contraindication to, or have they previously taken, any of the following treatments below (including any biosimilar presentations of the treatments shown)? If yes, please indicate from the options below. This information is requested to assist with support for navigating insurance coverage. Completion of this section is optional.

☐ HUMIRA® (adalimumab) ☐ REMICADE® (infliximab) ☐ CIMZIA® (certolizumab pegol) ☐ ENBREL® (etanercept)

☐ Otezla® (apremilast) ☐ RINVOQ® (upadacitinib) ☐ SIMPONI® (golimumab) ☐ SKYRIZI® (risankizumab-rzaa) ☐ STELARA® (ustekinumab)

☐ Taltz® (ixekizumab) ☐ TREMFYA® (guselkumab) ☐ BIMZELX® (bimekizumab-bkzx)

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Novartis Patient Support

COSENTYX® (secukinumab) EMA START FORM

* = REQUIRED

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

6. Prescription Information

HCP Preferred Specialty Pharmacy (optional): _____ ☐ The patient prescription has been sent to the specialty pharmacy noted here

* **Pharmacy Prescription:** ☐ Patient has completed a maintenance dose and is now moving to an increased maintenance dose

Product Information (Adult)	Dosage/Quantity (28 days)	Refills Rx
COSENTYX 150 mg ☐ Sensoready® Pen (1x150 mg/mL) ☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3	N/A
	☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	_____ refills
COSENTYX 300 mg ☐ UnoReady® Pen (1x300 mg/2 mL) ☐ Sensoready® Pen (2x150 mg/mL) ☐ Prefilled Syringe (2x150 mg/mL)	☐ **Loading Dose:** Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3	N/A
	☐ **Maintenance:** Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter	_____ refills
	☐ **Maintenance Increase (HS only):** Inject 300 mg subcutaneously every 2 weeks (For patients currently taking COSENTYX every 4 weeks as per label. Loading dose already completed.)	_____ refills

Product Information (Pediatric)	Dosage/Quantity (28 days)	Refills Rx
COSENTYX 75 mg (wt <50 kg) ☐ Prefilled Syringe (1x75 mg/mL)	☐ **Loading Dose:** Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3	N/A
	☐ **Maintenance:** Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter	_____ refills
COSENTYX 150 mg (wt ≥50 kg) **Moderate to Severe HS Only (wt ≥30 kg and <90 kg)** ☐ Sensoready® Pen (1x150 mg/mL) ☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3	N/A
	☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	_____ refills
COSENTYX 300 mg **Moderate to Severe HS Only (wt ≥90 kg)** ☐ UnoReady® Pen (1x300 mg/2 mL) ☐ Sensoready® Pen (2x150 mg/mL) ☐ Prefilled Syringe (2x150 mg/mL)	☐ **Loading Dose:** Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3	N/A
	☐ **Maintenance:** Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter	_____ 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 COSENTYX 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).

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Novartis Patient Support

Patient Authorization. I authorize my healthcare 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 healthcare 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 844-267-3689 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 healthcare 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 COSENTYX). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 844-267-3689.

[‡]**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 (*eg,* 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 (*eg,* 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 (*eg,* health plans, flexible spending or healthcare 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. Co-pay support for infusion administration cost not available in Rhode Island or Massachusetts.

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 COSENTYX Subcutaneous Injection only. Eligible patients must have private insurance and a valid prescription for COSENTYX, and a prior authorization, predetermination, or medical exception that has been denied. Program requires the submission of an appeal of the coverage denial within the first 90 days of enrollment to remain eligible. Program provides COSENTYX for free to eligible patients for up to 2 years, 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

Cosentyx® (secukinumab)