

Guide to completing the **FABHALTA® (iptacopan)** Start Form

For questions or support, reach out to your dedicated Novartis Access and Reimbursement team or contact Novartis Patient Support.



Phone:
833-99FABHA (833-993-2242)



Online:
www.fabhalta-startform.com



Fax:
877-44FABHA (877-443-2242)



Portal:
www.covermyeds.health



Not an actual patient.

Getting patients started

Novartis Patient Support will work with your practice to help your patient start on FABHALTA® (iptacopan). 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.

Do not fax patient medical records, except vaccination records.

Page 1

Sign up online at www.covermymeds.health or complete the entire form and fax to Novartis Patient Support at 877-44FABHA (877-443-2242). Questions? Contact 833-99FABHA (833-993-2242). An incomplete Start Form may delay the start of treatment.

Novartis Patient Support™

FABHALTA® (iptacopan) 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 FABHALTA: 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.

Patient/Authorized Representative Signature Date (MM/DD/YYYY) Check here if signed by an Authorized Representative.

CO-PAY PLUS! FOR FABHALTA

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 FABHALTA 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 833-99FABHA (833-993-2242). 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 Part D Medicaid Other: _____

Insurance/Payer	Plan Name	Policy Phone Number
Member ID Number	Group Number	

DO NOT FAX PATIENT MEDICAL RECORDS, EXCEPT VACCINATION RECORDS. ANY OTHER MEDICAL RECORDS WILL BE DESTROYED.

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

FA-11557509

Page 1 of 4

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:

- Indicate the applicable primary diagnosis code(s) for your patient here
- Multiple codes may apply for certain diagnosis codes. Reference the ICD-10 flashcard to help identify the correct one
- Fill in the appropriate code next to the checkbox labeled NO__.

- Make sure to check 1 of 2 checkboxes in Vaccination Support, section 6 on page 2, for the REMS requirement: ship as soon as possible or hold shipment
- Ensure the applicable box is checked for your patient's vaccination support needs in section 6
- Check that antibiotic prophylaxis administration is captured
- Document the appropriate vaccine type, brand, and administration date of the most recent dose for any vaccines already administered to your patient

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Novartis Patient Support **FABHALTA® (iptacopan) START FORM** * = REQUIRED

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

4. Prescriber Information

*** First Name** _____ *** Last Name** _____ *** Practice Name** _____

*** Address** _____ *** Practice Phone Number** _____ *** Practice Fax** _____

*** City** _____ *** State** _____ *** ZIP** _____ **Practice Contact Name** _____

*** Prescriber NPI Number** _____ **Practice Contact Phone Number** _____

5. Additional Information

*** Primary Diagnosis Code:**

D59.5 Paroxysmal nocturnal hemoglobinuria (PNH) Complement 3 glomerulopathy (C3G)

N02.B____ Recurrent and persistent immunoglobulin A nephropathy (IgAN) NO____A C3 glomerulonephritis (C3GN)

Other: _____ NO____.6 Dense deposit disease (DDD)

6. Vaccination Support

Please mark the checkbox relevant to your patient's vaccination support needs.

My patient requires vaccination support¹ to help comply with REMS requirements plus other Novartis Patient Support services My patient only requires vaccination support¹ to help comply with REMS requirements

Please provide relevant vaccination and antibiotic prophylaxis information for your patient below to support REMS requirements for FABHALTA:

▶ Antibiotic prophylaxis will be administered? Yes No If yes, start date: _____ (MM/DD/YYYY)

▶ If vaccinations have been administered, record the vaccine type, brand, and most recent administration date (MM/DD/YYYY) below

<p>MenACWY</p> <p><input type="checkbox"/> Menveo <input type="checkbox"/> Menactra <input type="checkbox"/> Penmenvry <input type="checkbox"/> MenQuadfi <input type="checkbox"/> Penbraya</p> <p>1st Dose Date: _____</p> <p><input type="checkbox"/> Menveo <input type="checkbox"/> Menactra <input type="checkbox"/> Penmenvry <input type="checkbox"/> MenQuadfi <input type="checkbox"/> Penbraya</p> <p>2nd Dose Date: _____</p>	<p>MenB</p> <p><input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba <input type="checkbox"/> Penbraya <input type="checkbox"/> Penmenvry</p> <p>1st Dose Date: _____</p> <p><input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba <input type="checkbox"/> Penbraya <input type="checkbox"/> Penmenvry</p> <p>2nd Dose Date: _____</p> <p><input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba</p> <p>3rd Dose Date: _____</p>	<p>Pneumococcal</p> <p><input type="checkbox"/> PCV13 <input type="checkbox"/> PCV15 <input type="checkbox"/> PCV20 <input type="checkbox"/> PCV21 <input type="checkbox"/> PPSV23</p> <p>1st Dose Date: _____</p> <p><input type="checkbox"/> PCV15 <input type="checkbox"/> PCV20 <input type="checkbox"/> PPSV23 If applicable</p> <p>2nd Dose Date: _____</p>
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FA-11557509 **FABHALTA®**
(iptacopan) 200 mg capsules | Page 2 of 4

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.

Sign up online at www.covermymeds.health or complete the entire form and fax to Novartis Patient Support at 877-44FABHA (877-443-2242). Questions? Contact 833-99FABHA (833-993-2242). An incomplete Start Form may delay the start of treatment.

Novartis Patient Support **FABHALTA® (iptacopan) START FORM** * = REQUIRED

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

7. Prescription Information

Preferred Specialty Pharmacy: Biologics CareMed Onco360 Other: _____
Please note: A patient's health plan may dictate specific specialty pharmacy.

* Pharmacy Prescription¹:

Product Information	Dosage	Quantity	Refills	Rx
FABHALTA 200 mg capsule	200 mg orally twice daily	<input type="checkbox"/> 60 capsules <input type="checkbox"/> 180 capsules	11 refills, or ____ refills	

FABHALTA is available through a Risk Evaluation and Mitigation Strategy (REMS) program. Additional information is available by telephone at 866-201-3101 or online at www.FABHALTA-REMS.com.

Vaccinate patients against encapsulated bacteria, including *Streptococcus pneumoniae* and *Neisseria meningitidis* (serogroups A, C, W, Y and B), according to current ACIP recommendations at least 2 weeks prior to initiation of FABHALTA. Current ACIP recommendations available at [https://www.cdc.gov/acip-recs/hcp/vaccine-specific](https://www.cdc.gov/acip/recs/hcp/vaccine-specific).

* Please select one of the options below and sign the prescriber attestation:

SHIP AS SOON AS POSSIBLE—NO PRESCRIBER HOLD
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history and certify that vaccinations will be completed OR antibiotic prophylaxis will be prescribed and vaccines will be administered as soon as possible. FABHALTA is authorized to be dispensed as soon as possible.

OR

HOLD SHIPMENT BUT START INSURANCE PROCESS—PRESCRIBER WILL BE CONTACTED FOR RELEASE
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history, and I request that the FABHALTA shipment be held with additional follow up provided to my office as necessary.

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 FABHALTA 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, except the vaccination records required for FABHALTA REMS compliance.**

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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FA-11557509 **FABHALTA**
(iptacopan) 200 mg capsules | Page 3 of 4

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 FABHALTA.

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.



Vaccination Support†

Our dedicated Novartis Patient Support team offers support to help your patients receive their required vaccinations.



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 833-99FABHA (833-993-2242), Monday-Friday, 8:00 AM-8:00 PM ET, excluding holidays, or visit www.fabhalta.com.

***Limitations apply.** Patients with private insurance coverage for FABHALTA may receive up to \$20,000 in annual co-pay benefits for the cost of FABHALTA and up to \$1,000 for qualifying vaccination costs (excluding administrative fees). Patient is responsible for any costs once the 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. 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, Puerto Rico, and select territories. Void where prohibited by law. Additional restrictions may apply. 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 this Program and discontinue support at any time without notice.

†Vaccination Support: Limitations apply. Please contact Novartis Patient Support at 833-99FABHA (833-993-2242), Monday through Friday, 8:00 AM-8:00 PM ET, excluding holidays for more information.

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.



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Novartis Patient Support™

FABHALTA® (iptacopan) START FORM

= REQUIRED

1. Patient Information

Mobile Home
 First Name Last Name Phone Number — *We'll keep you informed through non-marketing calls and texts.**
 Sex for Clinical Use: Male Female OK to Leave Voicemail for FABHALTA: Yes No
 Date of Birth (MM/DD/YYYY) Preferred Language: English Spanish Other: _____
 Address (No PO Box)
 City State ZIP Email

I give permission to disclose my personal health information to the following Caregiver (optional):

Mobile Home
 Caregiver Name Relationship to Patient Caregiver Phone Number — *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.

Patient/Authorized Representative Signature Date (MM/DD/YYYY) Check here if signed by an Authorized Representative.

CO-PAY PLUS[†] FOR FABHALTA

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 FABHALTA 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 833-99FABHA (833-993-2242). 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 Part D Medicaid Other: _____

Insurance/Payer Plan Name Policy Phone Number
 Member ID Number Group Number

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Novartis Patient Support

FABHALTA® (iptacopan) START FORM

* = REQUIRED

* Patient Name

* Date of Birth (MM/DD/YYYY)

4. Prescriber Information

* First Name

* Last Name

* Practice Name

* Address

* Practice Phone Number

* Practice Fax

* City

* State

* ZIP

Practice Contact Name

* Prescriber NPI Number

Practice Contact Phone Number

5. Additional Information

* Primary Diagnosis Code:

D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)

Complement 3 glomerulopathy (C3G)

N02.B Recurrent and persistent immunoglobulin A nephropathy (IgAN)

NO A C3 glomerulonephritis (C3GN)

Other: _____

NO 6 Dense deposit disease (DDD)

6. Vaccination Support

Please mark the checkbox relevant to your patient's vaccination support needs.

My patient requires vaccination support[†] to help comply with REMS requirements plus other Novartis Patient Support services

My patient only requires vaccination support[†] to help comply with REMS requirements

Please provide relevant vaccination and antibiotic prophylaxis information for your patient below to support REMS requirements for FABHALTA:

▶ Antibiotic prophylaxis will be administered? Yes No If yes, start date: _____ (MM/DD/YYYY)

▶ If vaccinations have been administered, record the vaccine type, brand, and most recent administration date (MM/DD/YYYY) below

MenACWY

Menveo Menactra Penmenvy

MenQuadfi Penbraya

1st Dose Date: _____

Menveo Menactra Penmenvy

MenQuadfi Penbraya

2nd Dose Date: _____

MenB

Bexsero Trumenba Penbraya Penmenvy

1st Dose Date: _____

Bexsero Trumenba Penbraya Penmenvy

2nd Dose Date: _____

Bexsero Trumenba

3rd Dose Date: _____

Pneumococcal

PCV13 PCV15 PCV20

PCV21 PPSV23

1st Dose Date: _____

PCV15 PCV20 PPSV23

If applicable

2nd Dose Date: _____

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FABHALTA® (iptacopan) START FORM

= REQUIRED

Patient Name

Date of Birth (MM/DD/YYYY)

7. Prescription Information

Preferred Specialty Pharmacy: Biologics CareMed Onco360 Other: _____

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

Pharmacy Prescription[§]:

Product Information	Dosage	Quantity	Refills	
FABHALTA 200 mg capsule	200 mg orally twice daily	<input type="checkbox"/> 60 capsules <input type="checkbox"/> 180 capsules	11 refills, or ____ refills	

FABHALTA is available through a Risk Evaluation and Mitigation Strategy (REMS) program. Additional information is available by telephone at 866-201-3101 or online at www.FABHALTA-REMS.com.

Vaccinate patients against encapsulated bacteria, including *Streptococcus pneumoniae* and *Neisseria meningitidis* (serogroups A, C, W, Y and B), according to current ACIP recommendations at least 2 weeks prior to initiation of FABHALTA. Current ACIP recommendations available at <https://www.cdc.gov/acip-recs/hcp/vaccine-specific>.

Please select one of the options below and sign the prescriber attestation:

SHIP AS SOON AS POSSIBLE—NO PRESCRIBER HOLD
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history and certify that vaccinations will be completed OR antibiotic prophylaxis will be prescribed and vaccines will be administered as soon as possible. FABHALTA is authorized to be dispensed as soon as possible.

OR

HOLD SHIPMENT BUT START INSURANCE PROCESS—PRESCRIBER WILL BE CONTACTED FOR RELEASE
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history, and I request that the FABHALTA shipment be held with additional follow up provided to my office as necessary.

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 FABHALTA 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, except the vaccination records required for FABHALTA REMS compliance.**

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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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 833-99FABHA (833-993-2242) 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 (e.g., to help you access and start on FABHALTA). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 833-99FABHA (833-993-2242).

†**Limitations apply.** Patients with private insurance coverage for FABHALTA may receive up to \$20,000 in annual co-pay benefits for the cost of FABHALTA and up to \$1,000 for qualifying vaccination costs (excluding administrative fees). Patient is responsible for any costs once the 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. 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, Puerto Rico, and select territories. Void where prohibited by law. Additional restrictions may apply. 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 this Program and discontinue support at any time without notice.

‡**Vaccination Support:** Limitations apply. Please contact Novartis Patient Support at 833-99FABHA (833-993-2242), Monday through Friday, 8:00 AM-8:00 PM ET, excluding holidays for more information.

§**The Bridge Program applies to FABHALTA only.** Eligible patients must have private insurance and a valid prescription for FABHALTA, and a prior authorization or an initial denial of coverage. Program requires the submission of a prior authorization or an appeal of the coverage denial within the first 45 days of enrollment to remain eligible. Program provides FABHALTA for free to eligible patients for up to 12 months, 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](#).