



Sign up online at www.covermymeds.health. Or complete entire form and fax to Novartis Patient Support at 866-433-2300. Questions? Contact 87-RHAPSIDO (877-427-7436). An incomplete Start Form may delay the start of treatment.

Novartis Patient Support™

RHAPSIDO® (remibrutinib) START FORM

* = REQUIRED

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 — *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 RHAPSIDO: 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 3.

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

CO-PAY PLUS⁺ FOR RHAPSIDO

Pay as little as \$0
 I have read and agree to the Co-Pay Plus Terms and Conditions on page 3.

GET ACCESS TO ONGOING SUPPORT

I'd like to sign up for access to ongoing support. I'll get RHAPSIDO tips, resources, and reminders from Novartis Patient Support at the phone number(s) I gave.

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 may vary. 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 87-RHAPSIDO (877-427-7436). 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: _____

* 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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* 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

Tax ID Number

* Practice Fax

5. Additional Information

* Primary Diagnosis Code:

L50.1 Idiopathic urticaria L50.8 Other (chronic, recurrent) urticaria L50.9 Urticaria, unspecified Other: _____

6. Prescription Information

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:

Product Information	Dosage	Quantity	Refills	Rx
RHAPSIDO 25 mg tablets	25 mg orally twice daily	<input type="checkbox"/> 60 tablets <input type="checkbox"/> 180 tablets	<input type="checkbox"/> 11 refills, or ___ refills	

7. 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 RHAPSIDO 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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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 co-pay 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 877-427-7436 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 RHAPSIDO). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 877-427-7436.

***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 toward 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.

The Bridge Program applies to RHAPSIDO® only. Eligible patients must have private insurance and a valid prescription for RHAPSIDO, and a delay or denial of coverage. Program requires the submission of a prior authorization or an appeal of the coverage denial within the first 90 days of enrollment to remain eligible. Program provides RHAPSIDO 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](#).