Sign up online at www.covermymeds.health or complete the entire form and send 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™

IV Formulation of COSENTYX® (secukinumab) START FORM

* = REQUIRED

1. Please check the box that indicates the benefits verification (BV) support your patient needs from Novartis Patient Support.

- ☐ **BV Only:** BV without prior authorization or appeals support
- ☐ **Full Service Support:** Support including the initial BV through prior authorization, appeals, and assessment of program eligibility
- ☐ **Monthly BV Support - optional:** I would like monthly support provided with service selected above as applicable

2. Patient Information

*First Name _____ *Last Name _____

*Date of Birth (MM/DD/YYYY) _____ *Sex for Clinical Use: ☐ Male ☐ Female

*Street Address (No PO Box) _____

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

*City _____ *State _____ *ZIP _____

OK to Leave Voicemail: ☐ Yes ☐ No

Email _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

3. Primary Authorized Representative Information

By completing this section, you represent and certify that you are at least eighteen (18) years of age and are legally authorized to act on behalf of the patient (e.g., parent of a minor, legal guardian, or individual holding a valid power of attorney).

*First Name _____ *Last Name _____

Relationship to Patient _____

Email _____

*Phone Number _____ ☐ Mobile ☐ Home *We'll keep the Parent/Authorized Representative informed through non-marketing calls and texts.**

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

OK to Leave Voicemail: ☐ Yes ☐ No

4. Caregiver Information

If the patient or the patient's Authorized Representative would like an individual to receive information and updates regarding the patient's care and participation in the program, as permitted by applicable authorization(s) and law, please complete below.

First Name _____ Last Name _____ Relationship to Patient _____ Phone Number _____ ☐ Mobile ☐ Home *We'll keep the Caregiver informed through non-marketing calls and texts.**

5. Patient Authorization and Additional Enrollment Consents

I have read and agree to the Patient Authorization on page 3.

*Print First Name _____ *Print Last Name _____ *Patient/Authorized Representative Signature X _____ *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 3.

6. 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

*Primary Medical Insurance ☐ Private ☐ Medicare Advantage ☐ Medicare A/B ☐ Medicaid ☐ Other: _____

Insurance/Payer _____ Plan Name _____ Policy Phone Number _____

Member ID Number _____ Group Number _____

Secondary Medical Insurance ☐ Private ☐ Medicare Advantage ☐ Medicare A/B ☐ Medicaid ☐ Other: _____

Insurance/Payer _____ Plan Name _____ Policy Phone Number _____

Member ID Number _____ Group Number _____

DO NOT SEND 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

Sign up online at www.covermymeds.health or complete the entire form and send 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.

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* = REQUIRED

* Patient First Name * Patient Last Name

* Date of Birth (MM/DD/YYYY)

7. Prescriber/Site of Administration Information

* First Name * Last Name

PTAN Number

* Address

* Practice Name

* City * State * ZIP

* Practice Phone Number * Practice Fax

* Prescriber NPI Number

Practice Contact Name

Tax ID Number

Practice Contact Phone Number * Practice Tax ID

* Practice NPI

8. Site of Administration Information

If patient is to receive treatment outside of the prescriber office, fill out Section 8 in addition to Section 7.

Location: ☐ Outpatient Facility ☐ Physician's Office ☐ Home Infusion ☐ Other: _____

Site Name

Expected COSENTYX Treatment Date (MM/DD/YYY)

Address

Site NPI Number Site Tax ID Number

City State ZIP

Site Contact Name

Site Phone Number Site Fax

9. Additional Information

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

☐ L40.5 Psoriatic Arthritis ☐ L73.2 Hidradenitis Suppurativa ☐ M45.0 Ankylosing Spondylitis ☐ M45.A Non-Radiographic Axial Spondyloarthritis

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

10. 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

* **Print First Name** * **Print Last Name** * **Prescriber Handwritten Signature** * **Date (MM/DD/YYYY)**

ATTN: Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).

DO NOT SEND 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

Novartis Patient Support

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, genetic information, including the results of genetic testing 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 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 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 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.

Please see full Novartis Pharmaceuticals Corporation Privacy Policy.

NOVARTIS

Cosentyx® (secukinumab)

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