Novartis
Patient Support™

Guide to completing the **RHAPSIDO® (remibrutinib) Start Form**

Phone:
87-RHAPSIDO (877-427-7436)

Online:
www.rhapsido-hcp.com

Fax:
866-433-2300

Portal:
www.covermymeds.health

For questions or support, reach out to your dedicated Novartis Access and Reimbursement Manager (ARM) or contact Novartis Patient Support by scanning the QR code.

Please see Important Safety Information on pages 4-5.
Please see full Prescribing Information, including Patient Information.

Rhapsido®
(remibrutinib) 25mg tablets

Novartis Patient Support

Guidance for required field | Guidance for patients

Getting patients started

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

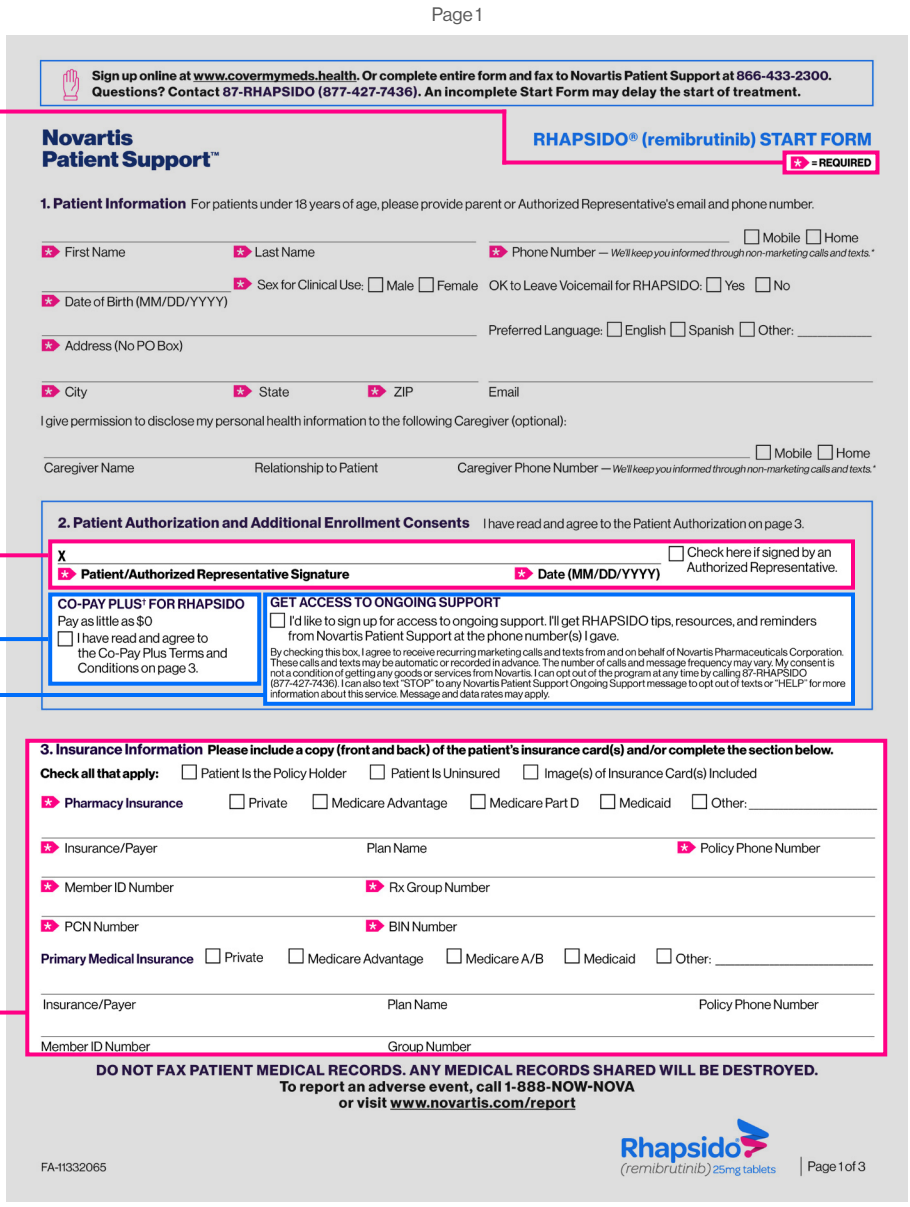
Look for this symbol ✱ as you fill out the Start Form to indicate the REQUIRED fields. When required fields are filled out completely, the Start Form will move through the submission process with ease, decreasing the need for the office to be contacted for missing information.

Obtain patient or authorized representative consent while your patient is present in the office. If needed, digital signatures can be completed online at www.HIPAAconsent.com.

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, which supports the benefits verification process.



Page 1

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.

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

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

FA-11332065

Rhapsido® (remibrutinib) 25mg tablets | Page 1 of 3

Please see Important Safety Information on pages 4-5.
Please see full Prescribing Information, including Patient Information.

Rhapsido® (remibrutinib) 25mg tablets

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.

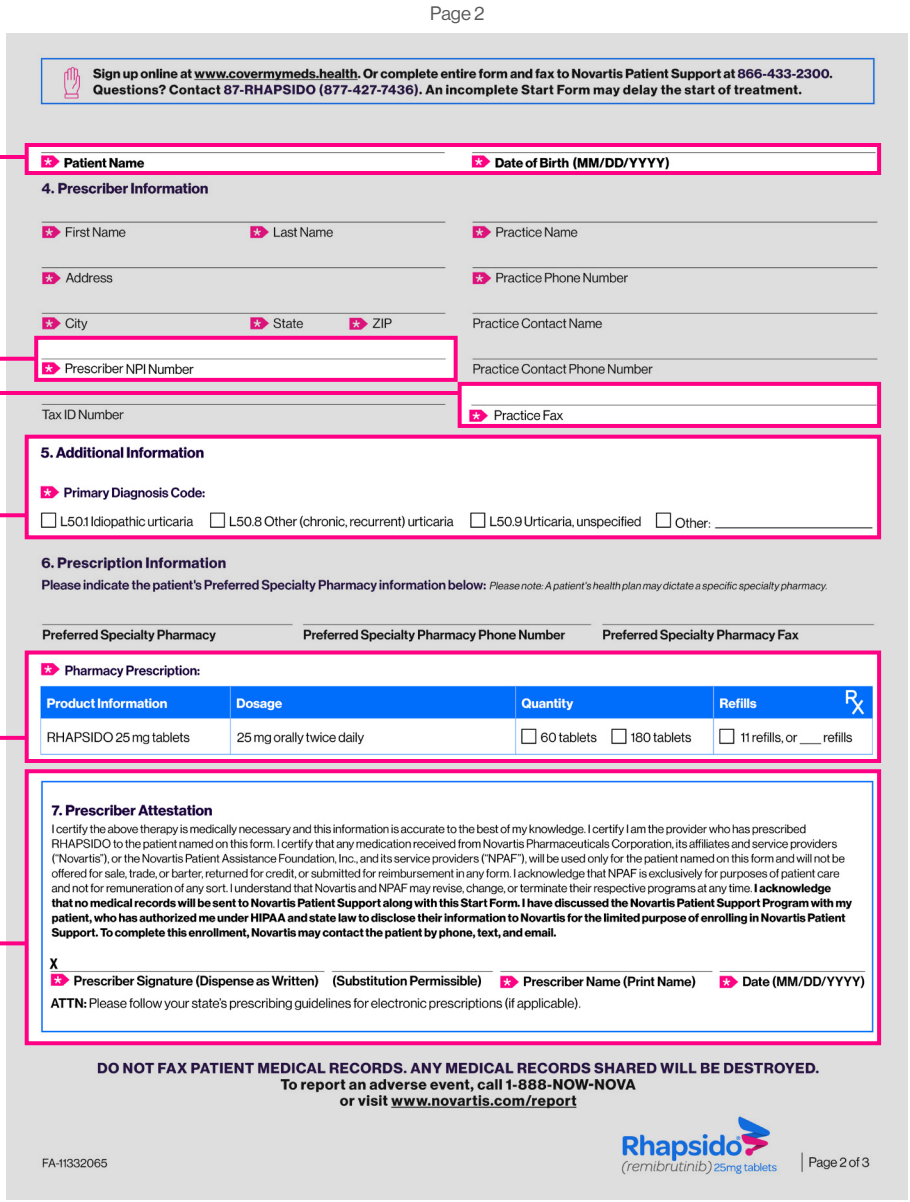
Make sure your patient's name and date of birth are present at the top of page 2.

Complete the Prescriber Information section. Don't forget the NPI Number and Practice Fax number fields to ensure communications are received from the Novartis Patient Support Center regarding your patient's Statement of Benefits.

Indicate the applicable primary diagnosis code(s) for your patient here.

Complete the Pharmacy Prescription table, including the applicable **quantity** and **refills**.

Please don't forget to sign, date, and print the provider attestation.



Page 2

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.

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	☐ 60 tablets ☐ 180 tablets	☐ 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).

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

FA-11332065

Rhapsido (remibrutinib) 25mg tablets | Page 2 of 3

Please see Important Safety Information on pages 4-5.
Please see full Prescribing Information, including Patient Information.

Rhapsido® (remibrutinib) 25mg tablets

Novartis Patient Support

RHAPSIDO® (remibrutinib) Indication and Important Safety Information

Indication

RHAPSIDO® (remibrutinib) is indicated for the treatment of chronic spontaneous urticaria (CSU) in adult patients who remain symptomatic despite H1 antihistamine treatment.

Limitations of Use: RHAPSIDO is not indicated for other forms of urticaria.

Important Safety Information

Warnings and Precautions

- Risk of Bleeding: Mucocutaneous-related bleeding occurred in 9% of patients who received RHAPSIDO. Interrupt treatment with RHAPSIDO if bleeding is observed and resume if the benefit is expected to outweigh the risk. Interrupt treatment with RHAPSIDO for 3 to 7 days pre- and post-surgery or invasive procedures. Use of antithrombotic agents concomitantly with RHAPSIDO may further increase the risk of bleeding. Consider the benefits and risks of antithrombotic agents when used with RHAPSIDO. Monitor for signs and symptoms of bleeding
- The use of live and live-attenuated vaccines should be avoided in patients receiving RHAPSIDO

Adverse Reactions

- The most common adverse reactions (incidence ≥ 3%) were nasopharyngitis, bleeding, headache, nausea, and abdominal pain

Drug Interactions

- Remibrutinib is a CYP3A4 substrate and a P-glycoprotein (P-gp) inhibitor
- Avoid use of RHAPSIDO with strong or moderate CYP3A4 inhibitors. Concomitant use with a strong or moderate CYP3A4 inhibitor increases remibrutinib exposure, which may increase the risk of RHAPSIDO adverse reactions
- Avoid use of RHAPSIDO with strong or moderate CYP3A4 inducers. Concomitant use with a strong or moderate CYP3A4 inducer decreases remibrutinib exposure, which may decrease the efficacy of RHAPSIDO
- Monitor more frequently for adverse reactions when using RHAPSIDO with P-gp substrates where minimal concentration changes may lead to serious adverse reactions (eg, digoxin). Remibrutinib increases exposure of P-gp substrates, which may increase the risk of adverse reactions related to P-gp substrates
- No data are available on concomitant use of RHAPSIDO with anticoagulants. The concomitant use of RHAPSIDO and anticoagulants was not allowed in clinical studies. Use of the antiplatelet agents, acetyl salicylic acid at doses up to 100 mg daily or clopidogrel up to 75 mg daily, was allowed in the RHAPSIDO clinical studies

Please see full Prescribing Information, including Patient Information.

Rhapsido® (remibrutinib) 25mg tablets

RHAPSIDO® (remibrutinib) Indication and Important Safety Information

Important Safety Information (cont)

Use In Specific Populations

- There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to RHAPSIDO during pregnancy
- Avoid use of RHAPSIDO in patients with mild, moderate, or severe hepatic impairment (Child-Pugh Class A, B, and C). RHAPSIDO exposure is increased in these patients relative to patients with normal hepatic function

Please see full Prescribing Information, including Patient Information.

Novartis Patient Support

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 RHAPSIDO® (remibrutinib).

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

Guidance and resources from our team to help answer questions as you navigate the insurance process, including benefits verification and 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

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 87-RHAPSIDO (877-427-7436), Monday through Friday, 8:00 AM-8:00 PM ET, excluding holidays, or visit www.rhapsido-hcp.com.

***Limitations apply.** Subject to annual co-pay benefit limit. Offer not valid under Medicare, Medicaid, or any other federal or state programs. Novartis reserves the right to rescind, revoke, or amend this program without notice. Additional limitations may apply. See complete Terms & Conditions at RHAPSIDO.com for details.

The information herein is provided for educational purposes only. Novartis cannot guarantee health plan coverage 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.

Please see Important Safety Information on pages 4-5.
Please see full Prescribing Information, including Patient Information.

NOVARTIS

Rhapsido® (remibrutinib) 25mg tablets

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

4/26

FA-11620276

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.

X _____ ☐ Check here if signed by an Authorized Representative.

* **Patient/Authorized Representative Signature** * **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

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.

*** 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 ℞
RHAPSIDO 25 mg tablets	25 mg orally twice daily	☐ 60 tablets ☐ 180 tablets	☐ 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).

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

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 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 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 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.

NOVARTIS

Rhapsido® (remibrutinib) 25mg tablets