COSENTYX® (secukinumab) Patient Reimbursement Request Form

To see if Novartis Patient Support can reimburse you for medication or treatment, please:

1. Fill out the Patient Information section below.
2. Provide a copy of the front and back of your prescription card.
3. Sign the Certification Statement at the end of this form.
4. Mail or fax your request, receipts, and this form to:

   Novartis Patient Support Claims Processing Department
   430 Mountain Avenue, Suite 105, New Providence, NJ 07974
   Fax: 631-822-2893

Patient Information*

Last Name:		First Name:		
Address 1:		Address 2:		
City:		State:		ZIP Code:
Date of Birth:		Phone Number:		
Sex for Clinical Use:	☐ Male ☐ Female	Amount Paid ($):		
Group #:		Rx ID #:		

*All Patient Information fields are required

Helpful Tip

You can find your Co-Pay Plus† Group # and Rx ID # in Novartis Patient Support communications

Supporting Materials

If you are submitting for reimbursement for a claim from a pharmacy, please provide:

Original pharmacy receipt and invoice. It must include:

- Patient name and address
- Pharmacy name, address, and phone number
- Healthcare provider name, address, and phone number
- Prescription number, fill date, drug name, strength, National Drug Code (NDC) number, and quantity
- Overall prescription price and co-pay amount paid
- A copy of the front and back of your prescription card

If you are submitting for reimbursement for a claim from a healthcare provider/site of care, please provide:

- Explanation of Benefits (EOB) from your insurance provider and CMS-1500, UB-92 or CMS-1450/UB-04 form from your healthcare provider
- Proof of payment
- A copy of the front and back of your insurance card(s)

Last Name:		First Name:	

Mail or fax this completed form and supporting materials to:

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Questions? Your Novartis Patient Support team can help. Call 844-COSENTYX (844-267-3689)

Don't Forget!

If you don't include all the required information, your claim will be rejected

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.

Last Name:		First Name:	

Patient Certification Statement

I certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by insurance, a flexible spending account (FSA), health savings account (HSA), or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, VA, DoD, or any other government (state or federally funded) program and that my use of this form is not prohibited by federal or state law. I understand and agree that I am liable for any misrepresentations herein to the full extent of applicable law.

Acknowledged and agreed (patient/caregiver signature required): _____ Date: _____

Please allow 4-6 weeks for processing and payment of claims.