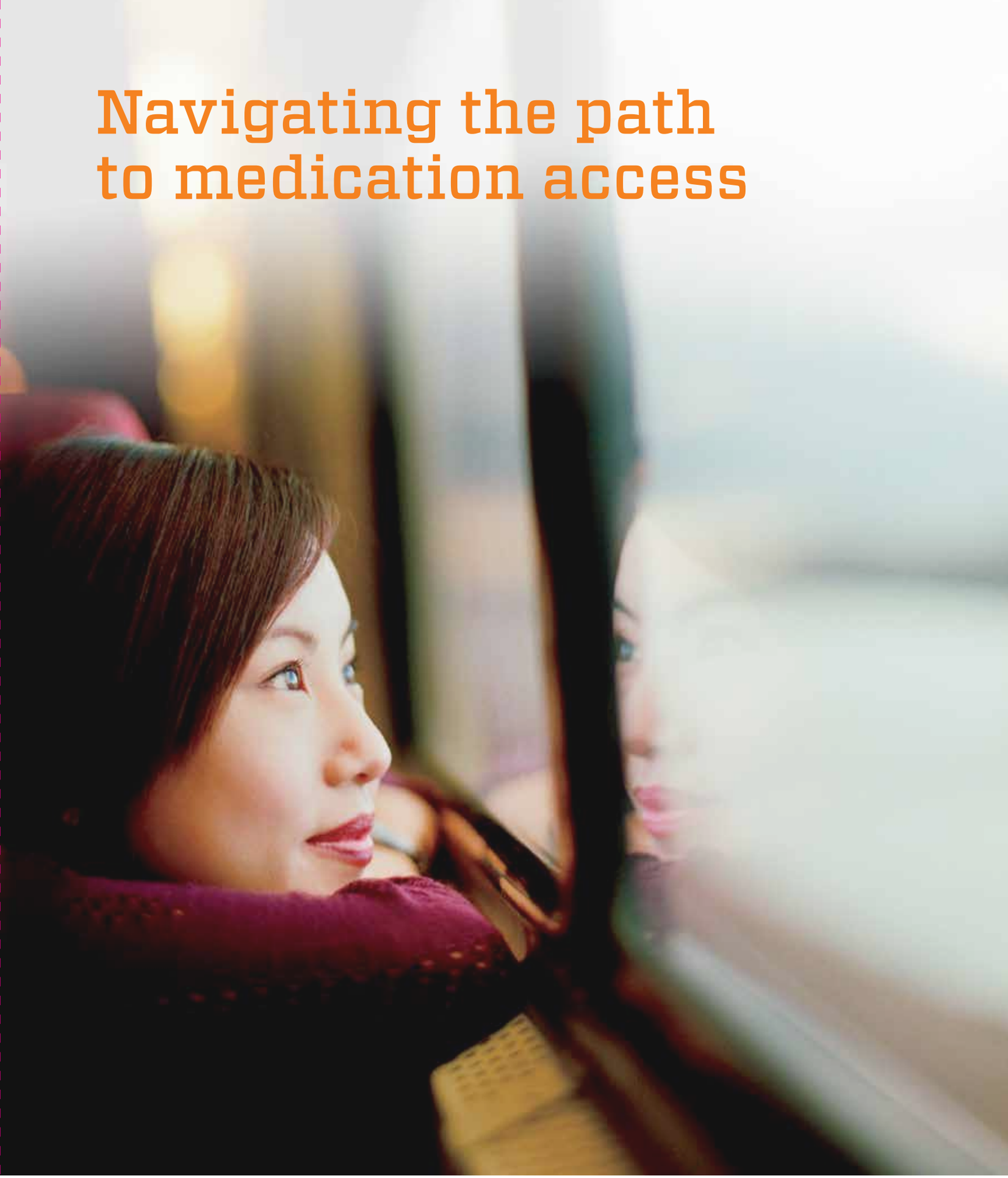
Navigating the path to medication access



NOVARTIS ONCOLOGY

Patient Assistance Now Oncology

Assistance. Access. Answers.

PANO helps patients access their medication

Helping your patients to access PANO is easy and fast. As part of the program, your patient will be assigned to a Patient Support Counselor who knows their story, owns their case, and follows up whenever necessary.

Assistance along the entire treatment journey

ENROLL

Complete enrollment form and fax to **1-888-891-4924**

OR

Visit online at **www.hcp.novartis.com/access**

REVIEW AND RESPONSE

PANO enrollment review, benefits investigation, and representative response

PATIENTS WITH COVERAGE

Options for patients with health coverage, but co-pay burdens
Call **1-800-282-7630**

Independent charitable foundations may assist with co-pay costs

Co-pay card reduces out-of-pocket expenses for eligible patients

Starter programs are available for certain products

If no available co-pay card

↓

Medicare Part D or Patient Assistance Program (PAP) appeal policies are available (if applicable)

You'll also find helpful tips and information on the next page. If you have further questions, please call us at 1-800-282-7630 or visit our website at www.hcp.novartis.com/access

OR

PATIENTS WITHOUT COVERAGE

Patients with no health coverage
Call **1-866-884-5906**

Novartis Patient Assistance Foundation (NPAF) evaluates eligibility for program

↓

If Medicare eligible, but not enrolled, will help identify the plans for which patients are eligible

You can determine whether a patient qualifies for the NPAF based on the following:

- Patient is a US resident
- Patient does not have private or public prescription coverage
- Patient meets financial eligibility requirements* and provides proof of income:

2015 Total Yearly Gross Income Range <500% Federal Poverty Limit for Oncology

Household Size	Total Yearly Gross Income†
1 Person	(up to) $58,850
2 People	(up to) $79,650
4 People	(up to) $121,250

*Financial eligibility requirements are based on the federal poverty level and are dependent on the specific product needed.
†Total yearly gross income is for the 48 contiguous states and the District of Columbia. It does not include Alaska or Hawaii.

PERSONALIZED SUPPORT

Rely on PANO to work with you and your patient

When it comes to medication access, your patient will receive professional assistance. PANO Patient Support Counselors have many years of health care experience, and talk to patients and providers every day. Below are some of the ways the team at PANO can help:

- Insurance verification
- Coding/billing questions
- Medicare education
- Assistance with denials/appeals
- Therapy-specific support programs for out-of-pocket costs
- Alternative funding searches and referrals to federal or state assistance programs
- Referrals to independent charitable foundations for assistance with co-pay costs
- Patient assistance for low-income and uninsured patients
- Patients prequalified via phone screening for the Patient Assistance Program (PAP) will be sent a 30-day supply of their needed medication while completing the application

Co-pay assistance through independent charitable foundations

Financial assistance may be available from independent charitable foundations for qualified patients who are unable to afford their co-pay costs. Below is a list of some of the foundations that may be able to provide financial support. Please check with funds directly for additional information about fund criteria and eligibility.

The Assistance Fund

- Financial assistance
- Melanoma

Visit **www.theassistancefund.org**, or call **1-855-845-3663**, to learn more.

Cancer*Care*

- Breast Cancer
- Breast Cancer (Metastatic)
- Renal Cell Carcinoma
- Multiple Myeloma

Visit **www.cancercarecopay.org**, or call **1-866-552-6729**, to learn more.

Good Days from CDF

- Multiple Myeloma
- Breast Cancer
- Myelodysplastic Syndromes
- Melanoma

Visit **www.gooddaysfromcdf.org**, or call **1-877-968-7233**, to learn more.

Healthwell Foundation

- Bone Metastases
- Carcinoid Tumors (Medicare patients only)
- Chronic Myeloid/Myelogenous Leukemia
- Melanoma

Visit **www.healthwellfoundation.org**, or call **1-800-675-8416**, to learn more.

Leukemia & Lymphoma Society

- Chronic Lymphocytic Leukemia
- Chronic Myeloid/Myelogenous Leukemia
- Multiple Myeloma
- Myelodysplastic Syndromes

Visit **www.lls.org/copay**, or call **1-877-557-2672**, to learn more.

National Organization for Rare Disorders

- Renal Cell Carcinoma

Visit **www.rarediseases.org**, or call **1-203-744-0100**, to learn more.

Partnership for Prescription Assistance

- Prescription drugs

Visit **www.pparx.org**, or call **1-888-477-2669**, to learn more.

Patient Access Network Foundation

- Acromegaly
- Bone Metastases
- Breast Cancer (Metastatic)
- Chronic Iron Overload
- Chronic Lymphocytic Leukemia
- Cushing Disease/ Cushing Syndrome
- Multiple Myeloma
- Myelodysplastic Syndromes
- Progressive Neuroendocrine Tumor of Pancreatic Origin
- Renal Cell Carcinoma
- Tuberous Sclerosis Complex
- Melanoma
- Chronic Immune Thrombocytopenia

Visit **www.panfoundation.org**, or call **1-866-316-PANF (7263)**, to learn more.

Patient Advocate Foundation

- Breast Cancer
- Multiple Myeloma
- Myelodysplastic Syndromes
- Renal Cell Carcinoma

Visit **www.copays.org**, or call **1-866-512-3861**, to learn more.

Patient Services, Inc.

- Acromegaly
- Chronic Myeloid/Myelogenous Leukemia
- Gastrointestinal Stromal Tumor (GIST)
- Melanoma
- Renal Cell Carcinoma

Visit **www.patientservicesinc.org**, or call **1-800-366-7741**, to learn more.

Rx Outreach

- Breast Cancer

Visit **www.rxoutreach.org**, or call **1-800-769-3880**, to learn more.

All nonprofit funds are subject to closure periodically. Please contact the fund directly for latest availability.

A legacy of patient assistance

Novartis Oncology has a legacy of patient advocacy and access support.

- The Novartis Patient Assistance Foundation, Inc. (NPAF) provides assistance to patients experiencing financial hardship who have no third-party insurance. In 2014, the NPAF provided $349 million in free oncology medication to more than 8900 patients
- Novartis Oncology is a proud supporter of independent charitable foundations for assistance with co-pay costs, providing over $322.2 million since 2004

The Novartis Oncology Universal Co-Pay Program*

A single co-pay card now exists for many Novartis Oncology brands. The program is simple to use, and it's easy to find out if patients are eligible. It's all part of our dedication to providing simplified support.

Patients can check eligibility and enroll in the Universal Co-Pay Program online at **www.copay.novartisoncology.com** or by calling **1-877-577-7756.**

*Limitations apply. Offer is not valid under Medicare, Medicaid, or any other federal or state program.

Novartis is committed to making sure patients have access to the oncology medicines they need

FOLLOW THESE INSTRUCTIONS TO COMPLETE THE NOVARTIS SERVICE REQUEST FORM FOR PATIENT SUPPORT

Fill in fax number based on medication

Please complete the form in its entirety for all medications being prescribed and submit ALL pages of the form to the specified fax number

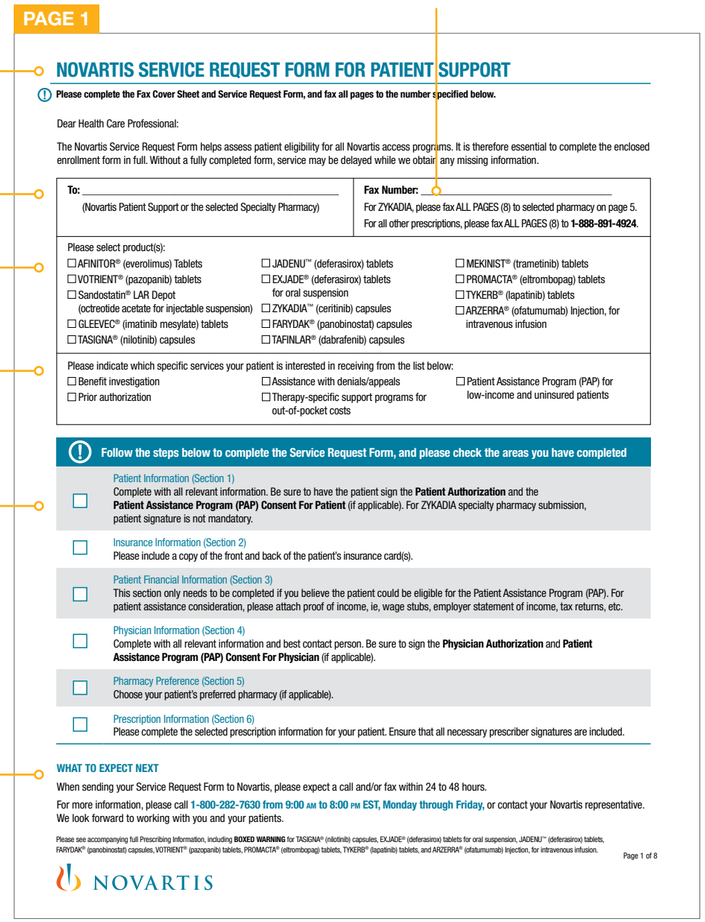
Indicate where it is being sent: Novartis Patient Support or the selected Specialty Pharmacy

Select prescription

Select support services that apply to your patient's needs

Check each box once section is complete

After faxing the form to Novartis, expect a call or fax back within 24–48 business hours



PAGE 1

NOVARTIS SERVICE REQUEST FORM FOR PATIENT SUPPORT

Please complete the Fax Cover Sheet and Service Request Form, and fax all pages to the number specified below.

Dear Health Care Professional:

The Novartis Service Request Form helps assess patient eligibility for all Novartis access programs. It is therefore essential to complete the enclosed enrollment form in full. Without a fully completed form, service may be delayed while we obtain any missing information.

To: _____
(Novartis Patient Support or the selected Specialty Pharmacy)

Fax Number: _____
For ZYKADIA, please fax ALL PAGES (8) to selected pharmacy on page 5.
For all other prescriptions, please fax ALL PAGES (8) to **1-888-891-4924**.

Please select product(s):

- ☐ AFINITOR® (everolimus) Tablets
- ☐ VOTRIENT® (pazopanib) tablets
- ☐ Sandostatin® LAR Depot (octreotide acetate for injectable suspension)
- ☐ GLEEVEC® (imatinib mesylate) tablets
- ☐ TASIGNA® (nilotinib) capsules
- ☐ JADENU™ (deferasirox) tablets
- ☐ EXJADE® (deferasirox) tablets for oral suspension
- ☐ ZYKADIA™ (ceritinib) capsules
- ☐ FARYDAK® (panobinostat) capsules
- ☐ TAFINLAR® (dabrafenib) capsules
- ☐ MEKINIST® (trametinib) tablets
- ☐ PROMACTA® (eltrombopag) tablets
- ☐ TYKERB® (lapatinib) tablets
- ☐ ARZERRA® (ofatumumab) injection, for intravenous infusion

Please indicate which specific services your patient is interested in receiving from the list below:

- ☐ Benefit investigation
- ☐ Prior authorization
- ☐ Assistance with denials/appeals
- ☐ Therapy-specific support programs for out-of-pocket costs
- ☐ Patient Assistance Program (PAP) for low-income and uninsured patients

Follow the steps below to complete the Service Request Form, and please check the areas you have completed

- ☐ Patient Information (Section 1)
  Complete with all relevant information. Be sure to have the patient sign the **Patient Authorization** and the **Patient Assistance Program (PAP) Consent For Patient** (if applicable). For ZYKADIA specialty pharmacy submission, patient signature is not mandatory.
- ☐ Insurance Information (Section 2)
  Please include a copy of the front and back of the patient's insurance card(s).
- ☐ Patient Financial Information (Section 3)
  This section only needs to be completed if you believe the patient could be eligible for the Patient Assistance Program (PAP). For patient assistance consideration, please attach proof of income, ie, wage stubs, employer statement of income, tax returns, etc.
- ☐ Physician Information (Section 4)
  Complete with all relevant information and best contact person. Be sure to sign the **Physician Authorization** and **Patient Assistance Program (PAP) Consent For Physician** (if applicable).
- ☐ Pharmacy Preference (Section 5)
  Choose your patient's preferred pharmacy (if applicable).
- ☐ Prescription Information (Section 6)
  Please complete the selected prescription information for your patient. Ensure that all necessary prescriber signatures are included.

WHAT TO EXPECT NEXT

When sending your Service Request Form to Novartis, please expect a call and/or fax within 24 to 48 hours.

For more information, please call **1-800-282-7630 from 9:00 AM to 8:00 PM EST, Monday through Friday,** or contact your Novartis representative. We look forward to working with you and your patients.

Please see accompanying full Prescribing Information, including **BOXED WARNING** for TASIGNA® (nilotinib) capsules, EXJADE® (deferasirox) tablets for oral suspension, JADENU™ (deferasirox) tablets, FARYDAK® (panobinostat) capsules, VOTRIENT® (pazopanib) tablets, PROMACTA® (eltrombopag) tablets, TYKERB® (lapatinib) tablets, and ARZERRA® (ofatumumab) injection, for intravenous infusion.

Page 1 of 8

NOVARTIS

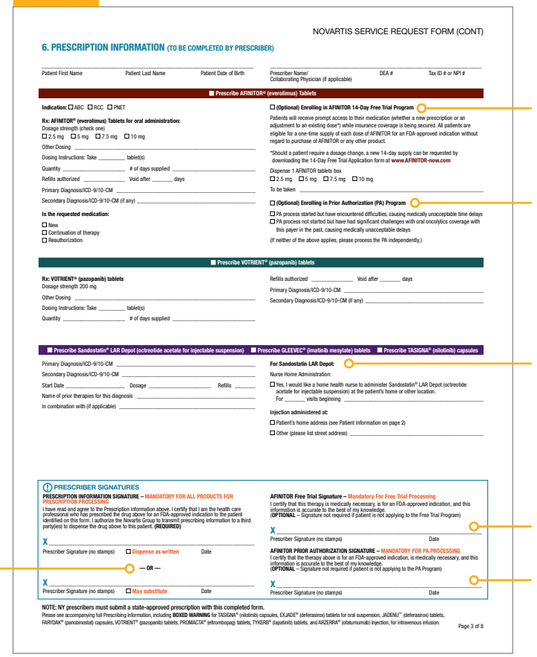
Prescription information sections

As you complete pages 3, 5, and 7, please consider the following:

- Prescriber should complete the prescription section for the product they are inquiring about
- Prescriber does not need to complete prescription section if not submitting a prescription
- If prescription is being submitted, complete entire prescription section, including information about dosing and ICD-9/10-CM
- Check which drug you are prescribing in the colored bars

Must sign either “Dispense as written” or “May substitute” Prescription Information signature, not both

PAGE 3



NOVARTIS SERVICE REQUEST FORM (CONT)

6. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Patient First Name | Patient Last Name | Patient Date of Birth

Prescriber Name/ Collaborating Physician (if applicable) | DEA # | Tax ID # or NPI #

■ Prescribe AFINITOR® (everolimus) Tablets

Indication: ☐ ABC ☐ RCC ☐ PNET

Rx: AFINITOR® (everolimus) Tablets for oral administration:
Dosage strength (check one)
☐ 2.5 mg ☐ 5 mg ☐ 7.5 mg ☐ 10 mg
Other Dosing
Dosing Instructions: Take _____ tablet(s)
Quantity _____ # of days supplied _____
Refills authorized _____ Void after _____ days
Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM (if any) _____

Is the requested medication:
☐ New
☐ Continuation of therapy
☐ Reauthorization

☐ **(Optional) Enrolling in AFINITOR 14-Day Free Trial Program**
Patients will receive prompt access to their medication (whether a new prescription or an adjustment to an existing dose*) while insurance coverage is being secured. All patients are eligible for a one-time supply of each dose of AFINITOR for an FDA-approved indication without regard to purchase of AFINITOR or any other product.
*Should a patient require a dosage change, a new 14-day supply can be requested by downloading the 14-Day Free Trial Application form at **www.AFINITOR-now.com**
Dispense 1 AFINITOR tablets box
☐ 2.5 mg ☐ 5 mg ☐ 7.5 mg ☐ 10 mg
To be taken _____

☐ **(Optional) Enrolling in Prior Authorization (PA) Program**
☐ PA process started but have encountered difficulties, causing medically unacceptable time delays
☐ PA process not started but have had significant challenges with oral oncolytics coverage with this payer in the past, causing medically unacceptable delays
(If neither of the above applies, please process the PA independently.)

■ Prescribe VOTRIENT™ (pazopanib) tablets

Rx: VOTRIENT® (pazopanib) tablets
Dosage strength 200 mg
Other Dosing
Dosing Instructions: Take _____ tablet(s)
Quantity _____ # of days supplied _____
Refills authorized _____ Void after _____ days
Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM (if any) _____

■ Prescribe Sandostatin® LAR Depot (octreotide acetate for injectable suspension) ■ Prescribe GLEEVEC® (imatinib mesylate) tablets ■ Prescribe TASIGNA® (nilotinib) capsules

Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM _____
Start Date _____ Dosage _____ Refills _____
Name of prior therapies for this diagnosis _____
In combination with (if applicable) _____

For Sandostatin LAR Depot:
Nurse Home Administration:
☐ Yes, I would like a home health nurse to administer Sandostatin® LAR Depot (octreotide acetate for injectable suspension) at the patient's home or other location.
For _____ visits beginning _____
Injection administered at:
☐ Patient's home address (see Patient Information on page 2)
☐ Other (please list street address) _____

ⓘ PRESCRIBER SIGNATURES
PRESCRIPTION INFORMATION SIGNATURE – MANDATORY FOR ALL PRODUCTS FOR PRESCRIPTION PROCESSING
I have read and agree to the Prescription Information above. I certify that I am the health care professional who has prescribed the drug above for an FDA-approved indication to the patient identified on this form. I authorize the Novartis Group to transmit prescribing information to a third party(ies) to dispense the drug above to this patient. **(REQUIRED)**
X _____
Prescriber Signature (no stamps) ☐ Dispense as written Date
— OR —
X _____
Prescriber Signature (no stamps) ☐ May substitute Date
NOTE: NY prescribers must submit a state-approved prescription with this completed form.
Please see accompanying full Prescribing Information, including **BOXED WARNING** for TASIGNA® (nilotinib) capsules, EXJADE® (deferasirox) tablets for oral suspension, JADENU™ (deferasirox) tablets, FARYDAK® (panobinostat) capsules, VOTRIENT® (pazopanib) tablets, PROMACTA® (eltrombopag) tablets, TYKERB® (lapatinib) tablets, and ARZERRA® (ofatumumab) injection, for intravenous infusion.

AFINITOR Free Trial Signature – Mandatory For Free Trial Processing
I certify that this therapy is medically necessary, is for an FDA-approved indication, and this information is accurate to the best of my knowledge.
(OPTIONAL – Signature not required if patient is not applying to the Free Trial Program)
X _____
Prescriber Signature (no stamps) Date

AFINITOR PRIOR AUTHORIZATION SIGNATURE – MANDATORY FOR PA PROCESSING
I certify that the therapy above is for an FDA-approved indication, is medically necessary, and this information is accurate to the best of my knowledge.
(OPTIONAL – Signature not required if patient is not applying to the PA Program)
X _____
Prescriber Signature (no stamps) Date

Page 3 of 8

Complete if enrolling patient in the AFINITOR 14-Day Free Trial Program

Complete if enrolling patient in the Prior Authorization (PA) Program

Complete if enrolling patient in the Nurse Home Administration for Sandostatin® LAR Depot

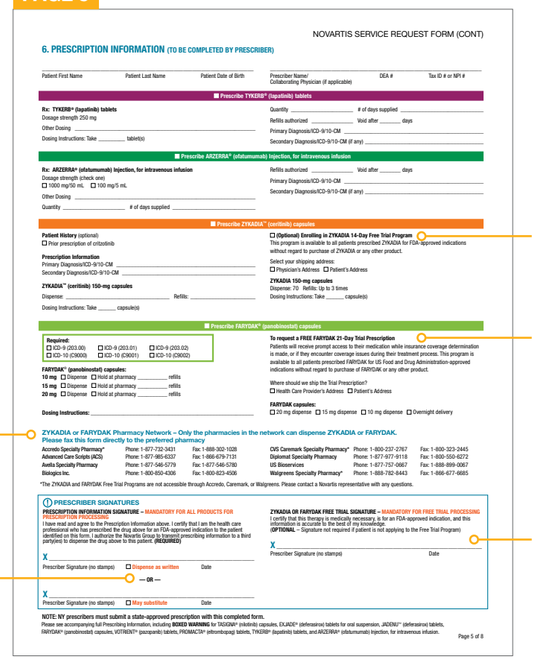
Must sign if enrolling patient in the AFINITOR 14-Day Free Trial Program

Must sign if enrolling patient in the AFINITOR® Prior Authorization (PA) Program

Must select a specialty pharmacy from the ZYKADIA™ or FARYDAK® Pharmacy Network if prescribing ZYKADIA or FARYDAK. Include number on fax cover sheet and submit to them directly

Must sign either “Dispense as written” or “May substitute” Prescription Information signature, not both

PAGE 5



NOVARTIS SERVICE REQUEST FORM (CONT)

6. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Patient First Name | Patient Last Name | Patient Date of Birth

Prescriber Name/ Collaborating Physician (if applicable) | DEA # | Tax ID # or NPI #

■ Prescribe TYKERB® (lapatinib) tablets

Rx: TYKERB® (lapatinib) tablets
Dosage strength 250 mg
Other Dosing
Dosing Instructions: Take _____ tablet(s)
Quantity _____ # of days supplied _____
Refills authorized _____ Void after _____ days
Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM (if any) _____

■ Prescribe ARZERRA® (ofatumumab) injection, for intravenous infusion

Rx: ARZERRA® (ofatumumab) injection, for intravenous infusion
Dosage strength (check one)
☐ 1000 mg/50 mL ☐ 100 mg/5 mL
Other Dosing
Quantity _____ # of days supplied _____
Refills authorized _____ Void after _____ days
Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM (if any) _____

■ Prescribe ZYKADIA™ (ceritinib) capsules

Patient History (optional)
☐ Prior prescription of crizotinib

Prescription Information
Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM _____

ZYKADIA™ (ceritinib) 150-mg capsules
Dispense: _____ Refills: _____
Dosing Instructions: Take _____ capsule(s)

☐ **(Optional) Enrolling in ZYKADIA 14-Day Free Trial Program**
This program is available to all patients prescribed ZYKADIA for FDA-approved indications without regard to purchase of ZYKADIA or any other product.
Select your shipping address:
☐ Physician's Address ☐ Patient's Address
ZYKADIA 150-mg capsules
Dispense: 70 Refills: Up to 3 times
Dosing Instructions: Take _____ capsule(s)

■ Prescribe FARYDAK® (panobinostat) capsules

Required:
☐ ICD-9 (203.00) ☐ ICD-9 (203.01) ☐ ICD-9 (203.02)
☐ ICD-10 (C9000) ☐ ICD-10 (C9001) ☐ ICD-10 (C9002)

FARYDAK® (panobinostat) capsules:
10 mg ☐ Dispense ☐ Hold at pharmacy _____ refills
15 mg ☐ Dispense ☐ Hold at pharmacy _____ refills
20 mg ☐ Dispense ☐ Hold at pharmacy _____ refills

Dosing Instructions:

To request a FREE FARYDAK 21-Day Trial Prescription
Patients will receive prompt access to their medication while insurance coverage determination is made, or if they encounter coverage issues during their treatment process. This program is available to all patients prescribed FARYDAK for US Food and Drug Administration-approved indications without regard to purchase of FARYDAK or any other product.
Where should we ship the Trial Prescription?
☐ Health Care Provider's Address ☐ Patient's Address
FARYDAK capsules:
☐ 20 mg dispense ☐ 15 mg dispense ☐ 10 mg dispense ☐ Overnight delivery

ZYKADIA or FARYDAK Pharmacy Network – Only the pharmacies in the network can dispense ZYKADIA or FARYDAK.
Please fax this form directly to the preferred pharmacy

Accredo Specialty Pharmacy*	Phone: 1-877-732-2431	Fax: 1-888-302-1028
Advanced Care Scripts (ACS)	Phone: 1-877-985-6337	Fax: 1-866-679-7131
Avella Specialty Pharmacy	Phone: 1-877-546-5779	Fax: 1-877-546-5780
Biologics Inc.	Phone: 1-800-850-4306	Fax: 1-800-823-4506
CVS Caremark Specialty Pharmacy*	Phone: 1-800-237-2767	Fax: 1-800-323-2445
Diplomat Specialty Pharmacy	Phone: 1-877-977-9118	Fax: 1-800-550-8272
US Bioservices	Phone: 1-877-752-0867	Fax: 1-888-899-0067
Walgreens Specialty Pharmacy*	Phone: 1-888-782-8443	Fax: 1-866-677-6685

*The ZYKADIA and FARYDAK Free Trial Programs are not accessible through Accredo, Caremark, or Walgreens. Please contact a Novartis representative with any questions.

ⓘ PRESCRIBER SIGNATURES
PRESCRIPTION INFORMATION SIGNATURE – MANDATORY FOR ALL PRODUCTS FOR PRESCRIPTION PROCESSING
I have read and agree to the Prescription Information above. I certify that I am the health care professional who has prescribed the drug above for an FDA-approved indication to the patient identified on this form. I authorize the Novartis Group to transmit prescribing information to a third party(ies) to dispense the drug above to this patient. **(REQUIRED)**
X _____
Prescriber Signature (no stamps) ☐ Dispense as written Date
— OR —
X _____
Prescriber Signature (no stamps) ☐ May substitute Date

ZYKADIA OR FARYDAK FREE TRIAL SIGNATURE – MANDATORY FOR FREE TRIAL PROCESSING
I certify that this therapy is medically necessary, is for an FDA-approved indication, and this information is accurate to the best of my knowledge.
(OPTIONAL – Signature not required if patient is not applying to the Free Trial Program)
X _____
Prescriber Signature (no stamps) Date

NOTE: NY prescribers must submit a state-approved prescription with this completed form.
Please see accompanying full Prescribing Information, including **BOXED WARNING** for TASIGNA® (nilotinib) capsules, EXJADE® (deferasirox) tablets for oral suspension, JADENU™ (deferasirox) tablets, FARYDAK® (panobinostat) capsules, VOTRIENT® (pazopanib) tablets, PROMACTA® (eltrombopag) tablets, TYKERB® (lapatinib) tablets, and ARZERRA® (ofatumumab) injection, for intravenous infusion.

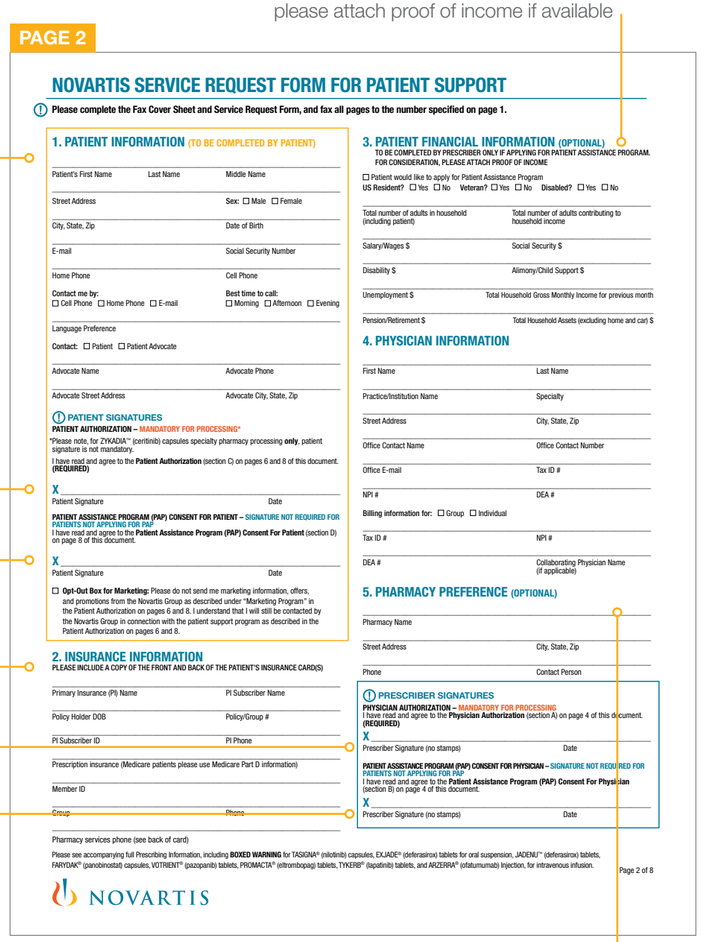
Page 5 of 8

Complete if enrolling patient in the ZYKADIA 14-Day Free Trial Program

Complete if enrolling patient in the FARYDAK 21-Day Free Trial Program

Must sign if enrolling patient in the ZYKADIA or FARYDAK Free Trial Program

PAGE 2



NOVARTIS SERVICE REQUEST FORM FOR PATIENT SUPPORT

ⓘ **Please complete the Fax Cover Sheet and Service Request Form, and fax all pages to the number specified on page 1.**

1. PATIENT INFORMATION (TO BE COMPLETED BY PATIENT)

Patient's First Name | Last Name | Middle Name
Street Address | Sex: ☐ Male ☐ Female
City, State, Zip | Date of Birth
E-mail | Social Security Number
Home Phone | Cell Phone
Contact me by: ☐ Cell Phone ☐ Home Phone ☐ E-mail | **Best time to call:** ☐ Morning ☐ Afternoon ☐ Evening
Language Preference
Contact: ☐ Patient ☐ Patient Advocate
Advocate Name | Advocate Phone
Advocate Street Address | Advocate City, State, Zip

ⓘ **PATIENT SIGNATURES**
PATIENT AUTHORIZATION – MANDATORY FOR PROCESSING*
*Please note, for ZYKADIA™ (ceritinib) capsules specialty pharmacy processing **only**, patient signature is not mandatory.
I have read and agree to the **Patient Authorization** (section C) on pages 6 and 8 of this document. **(REQUIRED)**
X _____
Patient Signature | Date

PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PATIENT – SIGNATURE NOT REQUIRED FOR PATIENTS NOT APPLYING FOR PAP
I have read and agree to the **Patient Assistance Program (PAP) Consent For Patient** (section D) on page 8 of this document.
X _____
Patient Signature | Date

☐ **Opt-Out Box for Marketing:** Please do not send me marketing information, offers, and promotions from the Novartis Group as described under “Marketing Program” in the Patient Authorization on pages 6 and 8. I understand that I will still be contacted by the Novartis Group in connection with the patient support program as described in the Patient Authorization on pages 6 and 8.

2. INSURANCE INFORMATION
PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF THE PATIENT'S INSURANCE CARD(S)
Primary Insurance (PI) Name | PI Subscriber Name
Policy Holder DOB | Policy/Group #
PI Subscriber ID | PI Phone
Prescription insurance (Medicare patients please use Medicare Part D information)
Member ID
Group | Phone
Pharmacy services phone (see back of card)

3. PATIENT FINANCIAL INFORMATION (OPTIONAL)
TO BE COMPLETED BY PRESCRIBER ONLY IF APPLYING FOR PATIENT ASSISTANCE PROGRAM. FOR CONSIDERATION, PLEASE ATTACH PROOF OF INCOME
☐ Patient would like to apply for Patient Assistance Program
US Resident? ☐ Yes ☐ No **Veteran?** ☐ Yes ☐ No **Disabled?** ☐ Yes ☐ No
Total number of adults in household (including patient) | Total number of adults contributing to household income
Salary/Wages $ | Social Security $
Disability $ | Alimony/Child Support $
Unemployment $ | Total Household Gross Monthly Income for previous month
Pension/Retirement $ | Total Household Assets (excluding home and car) $

4. PHYSICIAN INFORMATION
First Name | Last Name
Practice/Institution Name | Specialty
Street Address | City, State, Zip
Office Contact Name | Office Contact Number
Office E-mail | Tax ID #
NPI # | DEA #
Billing information for: ☐ Group ☐ Individual
Tax ID # | NPI #
DEA # | Collaborating Physician Name (if applicable)

5. PHARMACY PREFERENCE (OPTIONAL)
Pharmacy Name
Street Address | City, State, Zip
Phone | Contact Person

ⓘ **PRESCRIBER SIGNATURES**
PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING
I have read and agree to the **Physician Authorization** (section A) on page 4 of this document. **(REQUIRED)**
X _____
Prescriber Signature (no stamps) | Date
PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PHYSICIAN – SIGNATURE NOT REQUIRED FOR PATIENTS NOT APPLYING FOR PAP
I have read and agree to the **Patient Assistance Program (PAP) Consent For Physician** (section B) on page 4 of this document.
X _____
Prescriber Signature (no stamps) | Date

Page 2 of 8

This section includes all information required from patients

Section should only be completed if applying for the Patient Assistance Program (PAP). If applying, please attach proof of income if available

Patient must sign Patient Authorization for all medication (except ZYKADIA™ when being submitted to a specialty pharmacy). Consent language can be found on page 6

Patient should sign the Patient Assistance Program (PAP) Consent only if applying for PAP

For insured patients, provide a copy of the front and back of patient's insurance card(s)

Mandatory physician signature. Consent language can be found on page 4

Required physician signature if patient is applying for PAP

Complete if you or the patient have a preferred pharmacy

Prescription information sections

As you complete pages 3, 5, and 7, please consider the following:

- Prescriber should complete the prescription section for the product they are inquiring about
- Prescriber does not need to complete prescription section if not submitting a prescription
- If prescription is being submitted, complete entire prescription section, including information about dosing and ICD-9/10-CM
- Check which drug you are prescribing in the colored bars

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NOVARTIS SERVICE REQUEST FORM (CONT)

6. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Patient First Name | Patient Last Name | Patient Date of Birth | Prescriber Name/ Collaborating Physician (if applicable) | DEA # | Tax ID # or NPI #

☐ Prescribe TAFINLAR® (dabrafenib) capsules

Rx: TAFINLAR® (dabrafenib) capsules
Dosage strength (check one)
☐ 50 mg ☐ 75 mg
Other Dosing _____
Dosing Instructions: Take _____ capsule(s)

Quantity _____ # of days supplied _____
Refills authorized _____ Void after _____ days
Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM (if any) _____

☐ Prescribe MEKINIST® (trametinib) tablets

Rx: MEKINIST® (trametinib) tablets
Dosage strength (check one)
☐ 0.5 mg ☐ 2 mg
Other Dosing _____
Dosing Instructions: Take _____ tablet(s)

Quantity _____ # of days supplied _____
Refills authorized _____ Void after _____ days
Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM (if any) _____

☐ Prescribe PROMACTA® (eltrombopag) tablets

Rx: PROMACTA® (eltrombopag) tablets
Dosage strength (check one)
☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ 75 mg ☐ 100 mg
Other Dosing _____
Dosing Instructions: Take _____ tablet(s)

Quantity _____ # of days supplied _____
Refills authorized _____ Void after _____ days
Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM (if any) _____

☐ Prescribe JADENU™ (deferasirox) tablets ☐ Prescribe EXJADE® (deferasirox) tablets for oral suspension

Clinical Information
JADENU™ (deferasirox) tablets and EXJADE® (deferasirox) tablets for oral suspension are contraindicated in patients with:
- Serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance less than 40 mL/min
- Poor performance status
- High-risk myelodysplastic syndromes (MDS)
- Advanced malignancies
- Platelet counts less than 50 x 10^9/L
- Known hypersensitivity to deferasirox or any component of JADENU or EXJADE

☐ Yes, I have read and carefully considered the contraindications listed above for prescribing JADENU or EXJADE for this patient

Prior or current Desferal/deferoxamine patient? ☐ Yes ☐ No
Transfusion history: ☐ <10 units ☐ 10-20 units ☐ >20 units
Transfusions per month _____ Serum ferritin level/Date tested _____
Patient Specialty Pharmacy Preference for EXJADE:
☐ No Preference ☐ Accredo Health Group
☐ Walgreens Specialty Pharmacy ☐ US Bioservices

Prescription Information
# of days supplied: _____ # of refills: _____ Patient weight (kg): _____
Total daily dose for JADENU (must be divisible by 90 mg): _____
Total daily dose for EXJADE (must be divisible by 125 mg): _____
Directions: _____
Other prescribing information: _____

Primary Diagnosis
☐ Sickle Cell Anemia (ICD-9: 282.6)
☐ Thalassemia (ICD-9: 282.49)
☐ Lower-Risk Myelodysplastic Syndromes (ICD-9: 238.75)
(Note: higher-risk MDS is contraindicated)
☐ Other Anemia (please specify): _____

PRESCRIBER SIGNATURES

PRESCRIPTION INFORMATION SIGNATURE – MANDATORY FOR ALL PRODUCTS FOR PRESCRIPTION PROCESSING

I have read and agree to the Prescription Information above. I certify that I am the health care professional who has prescribed the drug above for an FDA-approved indication to the patient identified on this form. I authorize the Novartis Group to transmit prescribing information to a third party(ies) to dispense the drug above to this patient. **(REQUIRED)**

X _____
Prescriber Signature (no stamps) ☐ Dispense as written Date

— OR —

X _____
Prescriber Signature (no stamps) ☐ May substitute Date

Must sign either “Dispense as written” or “May substitute” Prescription Information signature, not both

NOTE: NY prescribers must submit a state-approved prescription with this completed form.

Please see accompanying full Prescribing Information, including **BOXED WARNING** for TASIGNA® (nilotinib) capsules, EXJADE® (deferasirox) tablets for oral suspension, JADENU™ (deferasirox) tablets, FARYDAK® (panobinostat) capsules, VOTRIENT® (pazopanib) tablets, PROMACTA® (eltrombopag) tablets, TYKERB® (lapatinib) tablets, and ARZERRA® (ofatumumab) injection, for intravenous infusion.

INSIDE THIS POCKET YOU WILL FIND THE NOVARTIS SERVICE REQUEST FORM FOR PATIENT SUPPORT. PLEASE FOLLOW THE INSTRUCTIONS TO COMPLETE THE FORM.

Let Novartis Oncology be an ally in getting your patient the medication you prescribe.

FOR MORE INFORMATION ABOUT PANO

Visit **www.hcp.novartis.com/access**, or call **1-800-282-7630**, to learn more.

NOVARTIS
ONCOLOGY

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