Universal Co-pay Program
Medical Benefit Co-pay Assistance Request Form

Here is the form you requested from Novartis Pharmaceuticals Corporation.

Please note that co-pay assistance requests can be submitted online at: CopayClaim.patientsavings.com

To receive your co-pay assistance funds, please complete the following 5 steps:

1. Fill out Patient Information
2. Fill out Co-pay Card Information
3. Read Terms and Conditions on page 2
4. Complete and sign Certification Statement and HIPAA Statement
5. Mail, submit online, or fax pages 1 and 2 of this form, along with the items listed on page 2

STEP 1 | Patient Information (please print)

Last Name: _____ First Name: _____

Address 1: _____ Address 2: _____

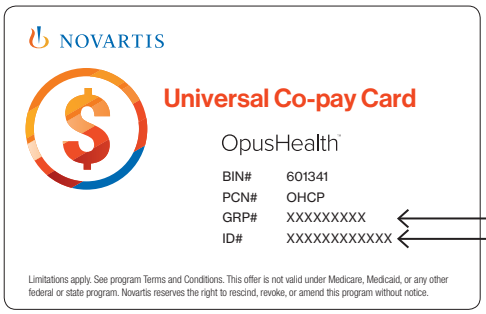
City: _____ State: _____ Zip: _____ Date of Birth: ____ / ____ /_____

Phone #: (____) _____ - _____ Email: _____

Physician Name: _____

Physician Phone #: (_____) _____ - _____ Physician Fax #: (_____) _____ - _____

STEP 2 | Universal Co-pay Card Information



GRP #:

☐☐☐☐☐☐☐☐☐

(This 9-digit # can be found beneath the PCN # on the front of your Universal Co-pay Card)

ID #:

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(This 12-digit # can be found beneath the GRP # on the front of your Universal Co-pay Card)

STEP 3 | Read Terms and Conditions on page 2

STEP 4 | Complete and sign Certification Statement and HIPAA Statement

I, _____, certify that my prescription medication for which I am seeking co-pay assistance is not paid for, in whole or in part, by any state or federal government program.
The information I am providing on or in connection with this co-pay assistance request form is accurate to the best of my knowledge, and the medication co-pay expenses for which I am seeking co-pay assistance were actually incurred.
I agree to the Terms and Conditions of the program, which are provided on this form.

Patient Signature: _____ **Date:** _____

I have read and agree to the HIPAA Patient Authorization on pages 3 and 4 of this document.

Patient Signature: _____ **Date:** _____

For medication co-pay assistance, send this completed form, along with the items listed below, via mail, online submission, or fax.

Have you already paid the co-pay for this prescription out of your own pocket before submitting this co-pay assistance request? ☐ Yes* ☐ No

*If you have answered Yes, you will receive a check instead of the reloadable Virtual Debit Card. You will receive a check within 7-10 business days post co-pay assistance approval.

1. A photocopy of the front and back of your **Universal Co-pay Card**
2. A photocopy of the front and back of your **primary insurance card** for prescription drugs
3. A copy of the **Explanation of Benefits (EOB) and UB-92 or CMS-1500 form**

OR

4. A copy of the proof of payment and original pharmacy receipt, or an invoice that must show: NDC, quantity, date of fill, and out-of-pocket expenses incurred

Mail: Novartis Oncology Claims Processing Department
c/o IQVIA
77 Corporate Drive
Bridgewater, NJ 08807

Fax: 1-973-781-4000

Online: CopayClaim.patientsavings.com

Note: After co-pay assistance request approval, you will receive a phone call with a virtual reloadable debit card (where applicable) with the amount of your out-of-pocket drug costs as determined by your insurance, minus the $25 per 28-day supply for which you are responsible under the program. With each additional approved claim, your debit card will be reloaded to cover the out-of-pocket costs covered by Novartis, up to the yearly maximum of $15,000. Please remember **you will need to call or provide your virtual debit card number to your physician's office as payment for your medicine, unless you have already paid that amount**.

For questions about the Universal Co-pay Program, the program offer, or this form, please call 1-877-577-7756.

Please note that you may authorize your physician's office to submit the required documentation, retain your debit card number, and use approved co-pay assistance amounts for your medicine costs. Ask your physician's office for details if you are interested.

The personal information that you supply on this form will be used only for the purpose of the co-pay assistance request and inquiries and may be disclosed to third parties acting on behalf of the manufacturer to support this.

Terms and Conditions: Under the Terms and Conditions of this program, the patient is responsible for a portion of their copayment for their prescribed medication, which varies based on the medication. After the patient pays such amount, Novartis will pay their remaining co-pay up to the combined annual limit, which also varies based on the medication. Please see Copay.NovartisOncology.com to understand the patient responsibility and combined annual limit for the medication you are prescribed. The Novartis Oncology Universal Co-pay Program includes the co-pay card, payment card, or rebate with a combined annual limit applicable to the medication prescribed (see Copay.NovartisOncology.com for details). Patient is responsible for any costs once the limit is reached in a calendar year. This offer is only available to patients with private insurance. The program is not available for patients who: (i) are enrolled in Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program; (ii) are not using insurance coverage at all; (iii) are enrolled in an insurance plan that 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 enrolled patients and is intended to be credited toward patient out-of-pocket obligations, including applicable copayments, coinsurance, and deductibles. Proof of purchase may be required. 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 his/her health plan related to the use of the program. Program is not valid where prohibited by law. Valid only in the United States and Puerto Rico. For certain medications, this offer is NOT valid for Massachusetts residents and is only valid for California residents that meet additional eligibility criteria. This program is not health insurance. This program may not be combined with any third-party rebate, coupon, or offer. Novartis reserves the right to rescind, revoke, or amend the program and discontinue support at any time without notice.

Non-marketing TCPA Consent:
By providing my information, I agree to be contacted by mail, email, telephone calls and text messages at the numbers and addresses provided in this enrollment. I also agree to be contacted by telephone calls and text messages made by or using automatic telephone dialing machines or artificial or prerecorded voice, at the number(s) provided in this enrollment, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys.

I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to notify the Companies promptly if any of my number(s) or address(es) change in the future.
I understand that my wireless service provider's message and data rates may apply.

I understand that the Companies do not permit my Personal Information to be used by its business partners for their own separate marketing purposes.

I understand and agree that Personal Information transmitted by email and cell phone cannot be secured against unauthorized access.

HIPAA PATIENT AUTHORIZATION
I give permission for my health care providers (HCPs), pharmacies, service providers and their contractors ("health care providers"), health insurer(s) and their contractors ("insurers") and third-party contractors, to disclose my personal information, including information about my insurance benefits, prescriptions, my medical condition and history, adherence to my treatment and my general health ("personal information") to Novartis Pharmaceuticals Corporation, its affiliates, business partners, and agents ("Novartis") so that Novartis may:

i. if I am eligible, coordinate the Universal Co-pay Program, including managing and communicating with me about the co-pay support options available to me.

I give permission to Novartis to disclose my personal information to my health care providers, insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above. I also give permission to Novartis to combine or aggregate any information collected from me with information Novartis may collect about me from other sources for the purpose of providing or administering program services.

I understand that once my personal information is disclosed, it may no longer be protected by federal privacy law and applicable state laws. Even though HIPAA may no longer apply, Novartis safeguards patient data through reasonable security measures and will use and share it only for the purposes specified in this authorization.

I understand that I may refuse to sign this authorization. I also may revoke (cancel) or get a copy of this authorization at any time by calling 1-877-577-7756 or by writing to the Customer Interaction Center, Novartis Pharmaceuticals Corporation, One Health Plaza, East Hanover, NJ 07936-1080. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a health care provider or insurer is disclosing my personal information to Novartis on an authorized, ongoing basis, my cancellation with Novartis will be effective with respect to any such health care provider or insurer as soon as they receive notice of my cancellation.

HIPAA PATIENT AUTHORIZATION (continued)

My refusal or future revocation will not affect my medical treatment or insurance benefits; however, if I revoke this authorization, I may no longer be able to participate in the Universal Co-pay Program and related programs. If I revoke this authorization, Novartis will stop using or sharing my information (except as necessary to end my participation in the program), but my revocation will not affect uses and disclosures of personal information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier. I also understand that the Universal Co-pay Program may change or end at any time without prior notification.

I agree to be contacted by mail, email, telephone calls and text messages at the numbers and addresses provided on this form for all purposes described in this patient authorization. I also agree to be contacted by Novartis and others on its behalf by telephone calls and text messages made by or using automatic telephone dialing machines or artificial or prerecorded voice, at the number(s) provided on this form, for all nonmarketing purposes, including, but not limited to, sending me materials and asking for my participation in surveys.

I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the email address(es) provided, and I agree to notify Novartis promptly if any of my number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that Novartis does not permit my personal information to be used by its business partners for their own separate marketing purposes.

I understand and agree that personal information transmitted by email and cell phone cannot be secured against unauthorized access.