

NOVARTIS ONCOLOGY SERVICE REQUEST FORM FOR PATIENT SUPPORT

For more information, please call 1-800-282-7630 from 9:00 AM to 8:00 PM ET, Monday through Friday.

UPDATE: KISQALI® (ribociclib) tablets added on page 3

RYDAPT® (midostaurin) capsules added on page 4

SIGNIFOR® (pasireotide) injection and SIGNIFOR® LAR (pasireotide) for injectable suspension added on page 8

 **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 Oncology Service Request Form helps assess patient eligibility for Novartis programs. It is therefore essential to complete the enclosed enrollment form in full, including all required signatures by you and your patient. Without a fully completed form, support may be delayed while we obtain any missing information.

To: Patient Assistance Now Oncology (PANO)

Fax Number: 1-888-891-4924



Follow the steps below to complete the Service Request Form, and please check the completed sections



Patient Information (Section 1)

Complete with all relevant information. Be sure the patient signs the **Patient Authorization**.



Patient Financial Information (Section 2)

This section only needs to be completed if applying for the Novartis Patient Assistance Foundation (NPAF), also known as the Patient Assistance Program (PAP). Please attach proof of income, ie, wage stubs, employer statement of income, tax returns, etc. Do not send original documents. Be sure the patient signs the **Patient Assistance Program (PAP) Consent For Patient** (if applicable).



Insurance Information (Section 3)

Please include a copy of the front and back of the patient's insurance card(s).



Physician Information (Section 4)

Complete with all relevant information and best contact person. Be sure to sign the **Physician Authorization**, and if the patient is applying, the **Patient Assistance Program (PAP) Consent For Physician**.



Prescription Information (Section 5)

Please complete the selected prescription information for your patient by (1) indicating the drug and dosage, (2) indicating which patient support services your patient is interested in receiving, and (3) completing the prescription dosing section. Be sure to sign the **Prescription Information Signature** at the bottom of the page.

For KISQALI, see page 3. For RYDAPT, see page 4. For all other oral therapies, see page 6. For injectable therapies, see page 8.

WHAT TO EXPECT NEXT

When sending your Service Request Form to Novartis, please expect a call and/or fax from Patient Assistance Now Oncology (PANO) within **24 to 48 hours**.

NOVARTIS ONCOLOGY SERVICE REQUEST FORM FOR PATIENT SUPPORT



Please complete the Fax Cover Sheet and Service Request Form, and fax all pages to 1-888-891-4924. For additional questions, call 1-800-282-7630.

1. PATIENT INFORMATION (TO BE COMPLETED BY PATIENT)

Patient's First Name		Last Name	Middle Name
Street Address			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, Zip		Date of Birth	
E-mail			
Home Phone		Cell Phone	
Contact me by:		Best time to call:	
<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> E-mail		<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	
Language Preference			
Contact: <input type="checkbox"/> Patient <input type="checkbox"/> Patient Caregiver/Advocate			
Caregiver/Advocate Name		Caregiver/Advocate Phone	
Caregiver/Advocate Street Address		Caregiver/Advocate City, State, Zip	

! PATIENT SIGNATURES (REQUIRED)

PATIENT AUTHORIZATION – MANDATORY FOR PROCESSING
I have read and agree to the Patient Authorization (section C) on pages 7 and 9 of this document.

X _____
Patient Signature Date

2. PATIENT FINANCIAL INFORMATION

NOVARTIS PATIENT ASSISTANCE FOUNDATION (NPAF) PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PATIENT – SIGNATURE ONLY REQUIRED FOR PATIENTS APPLYING FOR PAP

I have read and agree to the Patient Assistance Program (PAP) Consent For Patient (section D) on page 9 of this document.

X _____
Patient Signature Date

(FOR PATIENTS APPLYING FOR PAP)

ATTACH A COPY OF YOUR HOUSEHOLD'S MOST RECENT YEAR TAX RETURNS (1040, 1040EZ, 1099, ETC). DO NOT SEND ORIGINAL DOCUMENTS WITH YOUR APPLICATION.

Social Security Number _____
Total number of people in the home (Including self, please add all those who are living with you)
 1 2 3 4 5 6 or more
Number of Children: _____ Number of Adults: _____
US Resident: Yes No Veteran: Yes No Disabled: Yes No

List all sources of Gross Monthly Income:

Salary/Wages (All Sources):	\$ _____
Pension/Retirement:	+ \$ _____
Social Security:	+ \$ _____
Disability:	+ \$ _____
Unemployment Benefits:	+ \$ _____
Alimony/Child Support:	+ \$ _____
Total Gross Monthly Household Income:	= \$ _____

3. 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)	

4. PHYSICIAN INFORMATION

First Name	Last Name
Practice/Institution Name	Specialty
Street Address	City, State, Zip
Office Contact Name	Office Contact Number
Office Fax Number	Office E-mail
Billing Information for: <input type="checkbox"/> Group <input type="checkbox"/> Individual	
Tax ID #	NPI #
DEA #	

! PRESCRIBER SIGNATURES

(REQUIRED)
PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING

I have read and agree to the Physician Authorization (section A) on page 5 of this document.

X _____
Prescriber Signature (no stamps) Date

NOVARTIS PATIENT ASSISTANCE FOUNDATION (NPAF) PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PHYSICIAN – SIGNATURE ONLY REQUIRED FOR PATIENTS APPLYING FOR PAP

I have read and agree to the Patient Assistance Program (PAP) Consent For Physician (section B) on page 5 of this document.

X _____
Prescriber Signature (no stamps) Date

Patient First Name _____ Patient Last Name _____ Patient Date of Birth _____ Prescriber Name _____ DEA # _____ Tax ID # or NPI # _____

5. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

KISQALI® (ribociclib) tablets

Rx: KISQALI® (ribociclib) tablets

Tablet strength: 200 mg

KISQALI packaging comes in 28-day cycle packs, which include a 21-day supply of tablets, followed by 7 days off.

Please choose one of the following dose packs:

- KISQALI 600 mg Dose Pack: 3 tablets per day
- KISQALI 400 mg Dose Pack: 2 tablets per day
- KISQALI 200 mg Dose Pack: 1 tablet per day

Other Instructions _____

Refills authorized _____

Primary Diagnosis/ICD-10-CM _____

Secondary Diagnosis/ICD-10-CM _____

Rx: KISQALI® (ribociclib) tablets FEMARA® (letrozole) tablets Co-Pack

KISQALI tablet strength: 200 mg FEMARA tablet strength: 2.5 mg

KISQALI FEMARA Co-Pack packaging comes in 28-day cycle packs, which include a 21-day supply of KISQALI tablets, followed by 7 days off, and a 28-day supply of FEMARA tablets taken once daily throughout the 28-day cycle.

Please choose one of the following dose packs:

- KISQALI 600 mg and FEMARA 2.5 mg Dose Pack: 3 KISQALI tablets per day and 1 FEMARA tablet per day
- KISQALI 400 mg and FEMARA 2.5 mg Dose Pack: 2 KISQALI tablets per day and 1 FEMARA tablet per day
- KISQALI 200 mg and FEMARA 2.5 mg Dose Pack: 1 KISQALI tablet per day and 1 FEMARA tablet per day

Other Dosing Instructions _____

Refills authorized _____

Primary Diagnosis/ICD-10-CM _____

Secondary Diagnosis/ICD-10-CM _____

Transfer prescription to patient's pharmacy*: Preferred Pharmacy: _____ Phone: _____
 City: _____ State: _____ Fax: _____

*Subject to preferred pharmacy being within network for patient's prescription insurance.

Is your patient interested in applying for the Patient Assistance Program (PAP) for low-income and uninsured patients?
 Yes No

Make sure you and your patient sign the Patient Assistance Program Consent on page 2 and that the Patient Financial Information is provided. Also make sure to sign the Prescription Information Signature below.

KISQALI Patient Support Services

KISQALI Access Program

Commercially insured patients who are taking KISQALI for an FDA-approved indication and are experiencing an insurance coverage delay may be eligible for free medication while awaiting coverage, for up to 5 months. Patients receiving benefits under Medicare, Medicaid, or any other federal or state program are not eligible for this offer. Participation is not a guarantee of availability of insurance coverage or alternative financial assistance. Offer is not contingent upon purchase requirements of any kind. Novartis reserves the right to rescind, revoke, or amend the program without notice.

Prescription Rx for KISQALI:

Tablet strength: 200 mg

Please choose one of the following dose packs:

- KISQALI 600 mg Dose Pack: 3 tablets per day
- KISQALI 400 mg Dose Pack: 2 tablets per day
- KISQALI 200 mg Dose Pack: 1 tablet per day

Other Instructions _____

Up to 4 refills

Prescription Rx for KISQALI FEMARA Co-Pack:

KISQALI tablet strength: 200 mg FEMARA tablet strength: 2.5 mg

Please choose one of the following dose packs:

- KISQALI 600 mg and FEMARA 2.5 mg Dose Pack: 3 KISQALI tablets per day and 1 FEMARA tablet per day
- KISQALI 400 mg and FEMARA 2.5 mg Dose Pack: 2 KISQALI tablets per day and 1 FEMARA tablet per day
- KISQALI 200 mg and FEMARA 2.5 mg Dose Pack: 1 KISQALI tablet per day and 1 FEMARA tablet per day

Other Dosing Instructions _____

Up to 4 refills

ACCESS PROGRAM SIGNATURE – MANDATORY FOR ACCESS PROGRAM 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. I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____

Prescriber Signature (no stamps)

Date

KISQALI Care @ Home Monitoring

Patients who are taking KISQALI for an FDA-approved indication may be eligible to receive certain monitoring tests at their home for free. This program is not available for patients with Medicare, Medicaid, or any other federal or state program. Program not available for residents of Michigan, Minnesota, or Rhode Island. Prescribing physician will be notified of results or if patient is unable to have the monitoring conducted at home. This program is subject to termination or modification at any time.

	Baseline?	Continued Tests per Label?†	Additional Follow-up Tests?	If Additional, Please Specify
ECG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Labs (CBC, LFT, Electrolytes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

†Label requires: **ECG:** Day 14 of Cycle 1 and Day 1 of Cycle 2 **CBC and LFT:** Day 14 of Cycle 1, Day 1 and 14 of Cycle 2, Day 1 of Cycles 3-6 **Electrolytes:** Day 1 of each cycle after baseline

PRESCRIBER SIGNATURES

PRESCRIPTION INFORMATION SIGNATURE – REQUIRED FOR ALL PRODUCTS

I certify that I am the health care professional who has prescribed the above therapy to the previously identified patient, that I have made an independent judgment that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____

- OR -

X _____

Prescriber Signature (no stamps)

Dispense as written

Date

Prescriber Signature (no stamps)

May substitute

Date

NOTE: DE, NY, and NJ prescribers, or any other state where this is a requirement, must submit a state-approved prescription with this completed form.

NOTE: Depending on selected programs, additional prescriptions may be required.

Patient First Name _____ Patient Last Name _____ Patient Date of Birth _____ Prescriber Name _____ DEA # _____ Tax ID # or NPI # _____

5. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

RYDAPT® (midostaurin) capsules

Rx: RYDAPT® (midostaurin) capsules

Capsule strength: 25 mg

RYDAPT packaging comes in the following dose packs:

RYDAPT Dose Pack: 56-capsule pack

RYDAPT Dose Pack: 112-capsule pack

Primary Diagnosis/ICD-10-CM _____

Secondary Diagnosis/ICD-10-CM _____

Prior Treatment (if any) _____

Dosing Instructions: Take _____ capsule(s) _____ time(s) per day

Dispense # _____ # of days supplied _____

Refills authorized _____

Please fill out completely:

Current Site of Care: Hospital (inpatient) Outpatient Other

Please specify if other _____

If currently inpatient, will patient soon be in outpatient setting? Yes No

Next scheduled cycle:

Projected start date _____

Projected RYDAPT start date _____

Has the patient been:

FLT3 tested? Yes No

FLT3 mutation detected? Yes No Awaiting results

Is the patient a candidate for allogeneic transplant? Yes No

Transfer prescription to patient's pharmacy*:

Preferred Pharmacy: _____ Phone: _____

City: _____ State: _____ Fax: _____

*Subject to preferred pharmacy being within network for patient's prescription insurance.

Is your patient interested in applying for the Patient Assistance Program (PAP) for low-income and uninsured patients?

Yes No

Make sure you and your patient sign the Patient Assistance Program Consent on page 2 and that the Patient Financial Information is provided. Also make sure to sign the Prescription Information Signature below.

RYDAPT Free Supply Programs

Patients who are taking RYDAPT in accordance with the FDA-approved prescribing information and are new to therapy or experiencing an insurance coverage delay may be eligible for a free supply of RYDAPT. Participation is not a guarantee of availability of insurance coverage or alternative financial assistance programs. Offer is not contingent upon purchase requirements of any kind. Novartis reserves the right to rescind, revoke, or amend this program without notice.

Prescription Rx for RYDAPT:

Capsule strength: 25 mg

RYDAPT Dose Pack: 56-capsule pack (14-day supply for 28-day cycle)

RYDAPT Dose Pack: 112-capsule pack x2 (28-day supply)

Dosing Instructions for 28-day trial:

Take _____ capsule(s) _____ time(s) per day for 28-day cycle

Dispense: 28-day cycle. Up to 2 refills. Terms and conditions vary based on diagnosis.

RYDAPT FREE SUPPLY PROGRAMS SIGNATURE – MANDATORY FOR RYDAPT FREE SUPPLY PROGRAMS PROCESSING

I certify that this therapy is medically necessary, is prescribed in accordance with the FDA-approved prescribing information, and this information is accurate to the best of my knowledge. I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____

Prescriber Signature (no stamps)

Date

1 PRESCRIBER SIGNATURES

PRESCRIPTION INFORMATION SIGNATURE – REQUIRED FOR ALL PRODUCTS

I certify that I am the health care professional who has prescribed the above therapy to the previously identified patient, that I have made an independent judgment that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____

Prescriber Signature (no stamps)

Dispense as written

Date

- OR - **X** _____

Prescriber Signature (no stamps)

May substitute

Date

NOTE: DE, NY, and NJ prescribers, or any other state where this is a requirement, must submit a state-approved prescription with this completed form.
NOTE: Depending on selected programs, additional prescriptions may be required.

A. PHYSICIAN AUTHORIZATION

My signature on page 2 certifies that I am the physician who has prescribed the selected drug to the patient identified on page 2. I certify that I have made an independent judgment that this therapy is medically necessary, and that I have provided the patient with materials that describe the Novartis Oncology Service Request Form For Patient Support.

Finally, for the purposes of transmitting this prescription, I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, third-party contractors, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by the patient named on page 2.

B. PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PHYSICIAN (MANDATORY FOR PATIENTS ENROLLING IN THE PATIENT ASSISTANCE PROGRAM)

My signature on page 2 certifies that the person listed on page 2 is my patient for whom I have prescribed the drug identified on this form. For the purposes of transmitting this prescription, I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, service providers, third-party contractors, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy. I certify that any medications received from Novartis in connection with this application will be used only for the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. I acknowledge that I have assisted the patient in enrolling in the Novartis PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort. I also agree that Novartis has the right to contact the patient directly to confirm receipt of medications, and I understand that Novartis may revise, change, or terminate this program at any time. Finally, to the best of my knowledge, the patient listed on page 2 meets Novartis' eligibility criteria for the PAP.

Patient First Name _____ Patient Last Name _____ Patient Date of Birth _____ Prescriber Name _____ DEA # _____ Tax ID # or NPI # _____

5. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Step 1: Please select product(s)	Step 2: Please indicate which specific support services your patient is interested in receiving (check all that apply)			Step 3: Please fill in the information below
	Patient Support Services		Patient Assistance Program	
	Benefits investigation and information about financial support	Free Trial Program	Patient Assistance Program (PAP) for low-income and uninsured patients†	
<input type="checkbox"/> Rx: AFINITOR® (everolimus) Tablets Tablet strength (check one) <input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 7.5 mg <input type="checkbox"/> 10 mg	<input type="checkbox"/>	<input type="checkbox"/> 14-Day*	<input type="checkbox"/>	Product _____ Primary Diagnosis/ICD-10-CM _____ Secondary Diagnosis/ICD-10-CM _____ Prior Treatment (if any) _____
<input type="checkbox"/> Rx: GLEEVEC® (imatinib mesylate) tablets Tablet strength (check one) <input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg	<input type="checkbox"/>	N/A	<input type="checkbox"/>	Take _____ tablet(s)/capsule(s) _____ time(s) per day Quantity _____ # of days supplied _____ Refills authorized _____
<input type="checkbox"/> Rx: TAFINLAR® (dabrafenib) capsules Capsule strength (check one) <input type="checkbox"/> 50 mg <input type="checkbox"/> 75 mg	<input type="checkbox"/>	<input type="checkbox"/> 30-Day*	<input type="checkbox"/>	Please fill in if prescribing more than 1 product Product _____ Primary Diagnosis/ICD-10-CM _____ Secondary Diagnosis/ICD-10-CM _____ Prior Treatment (if any) _____
<input type="checkbox"/> Rx: MEKINIST® (trametinib) tablets Tablet strength (check one) <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 2 mg	<input type="checkbox"/>	<input type="checkbox"/> 30-Day*	<input type="checkbox"/>	
<input type="checkbox"/> Rx: PROMACTA® (eltrombopag) tablets Tablet strength (check one) <input type="checkbox"/> 12.5 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 75 mg	<input type="checkbox"/>	N/A	<input type="checkbox"/>	
<input type="checkbox"/> Rx: JADENU® (deferasirox) tablets Tablet strength (check one) <input type="checkbox"/> 90 mg <input type="checkbox"/> 180 mg <input type="checkbox"/> 360 mg	<input type="checkbox"/>	N/A	<input type="checkbox"/>	Take _____ tablet(s)/capsule(s) _____ time(s) per day Quantity _____ # of days supplied _____ Refills authorized _____
<input type="checkbox"/> Rx: EXJADE® (deferasirox) tablets for oral suspension Tablet strength (check one) <input type="checkbox"/> 125 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/>	N/A	<input type="checkbox"/>	
<input type="checkbox"/> Rx: TASIGNA® (nilotinib) capsules Capsule strength (check one) <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/>	N/A	<input type="checkbox"/>	In addition to the information above, please fill in if prescribing JADENU or EXJADE: 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)
<input type="checkbox"/> Rx: TYKERB® (lapatinib) tablets Tablet strength 250 mg	<input type="checkbox"/>	<input type="checkbox"/> 14-Day*	<input type="checkbox"/>	
<input type="checkbox"/> Rx: VOTRIENT® (pazopanib) tablets Tablet strength 200 mg	<input type="checkbox"/>	<input type="checkbox"/> 14-Day*	<input type="checkbox"/>	*Eligible patients receive a free 1-time supply of the prescribed drug for an FDA-approved indication (per prescribed strength) without regard to purchase of their prescribed drug or any other product. Novartis reserves the right to rescind, revoke, or amend the program without notice. Please sign the Prescription Information Signature. †Make sure you and your patient sign the Patient Assistance Program Consent on page 2 and that the Patient Financial Information is provided. Also make sure to sign the Prescription Information Signature below.
<input type="checkbox"/> Rx: ZYKADIA® (ceritinib) capsules Capsule strength 150 mg	<input type="checkbox"/>	<input type="checkbox"/> 14-Day*	<input type="checkbox"/>	
<input type="checkbox"/> Rx: Other Novartis Oncology Product _____ Dosage strength _____	<input type="checkbox"/>	N/A	<input type="checkbox"/>	

1 PRESCRIBER SIGNATURES

PRESCRIPTION INFORMATION SIGNATURE – REQUIRED FOR ALL PRODUCTS

I certify that I am the health care professional who has prescribed the above therapy to the previously identified patient, that I have made an independent judgment that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____ — OR — **X** _____
 Prescriber Signature (no stamps) **Dispense as written** Date Prescriber Signature (no stamps) **May substitute** Date

NOTE: DE, NY, and NJ prescribers, or any other state where this is a requirement, must submit a state-approved prescription with this completed form.
 NOTE: Depending on selected programs, additional prescriptions may be required.

C. PATIENT AUTHORIZATION FOR PATIENT SUPPORT SERVICES

Please read the following carefully, then sign and date where indicated on page 2.

I give permission for my health care providers (HCPs), pharmacies, health insurer(s), and third-party contractors or service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition and health (“Personal Information”) to Novartis Pharmaceuticals Corporation, its affiliates, business partners, service providers, third-party contractors, and agents (together, the “Novartis Group”) so that the Novartis Group can provide me with the Patient Support Services available for the Novartis Oncology medication prescribed by my HCP on this Service Request Form to (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with this Novartis Oncology medication, (ii) coordinate my receipt of, and payment for this Novartis Oncology medication, (iii) facilitate my access to this Novartis Oncology medication, (iv) provide me with information about this Novartis Oncology medication, disease awareness and management programs and educational materials, (v) manage the Patient Support Services, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the Patient Support Services.

I give permission to the Novartis Group to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from the Novartis Pharmaceuticals Corporation in exchange for disclosing my Personal Information to Novartis Pharmaceuticals Corporation and/or for providing me with therapy support services.

I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by calling 1-888-NOW-NOVA (1-888-669-6682) or by writing to the Customer Interaction Center, Novartis Pharmaceuticals Corporation, One Health Plaza, East Hanover, NJ 07936-1080. My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctor(s); however, if I revoke this authorization, I may no longer be eligible to participate in the Patient Support Services. If I revoke this authorization, the Novartis Group will stop using or sharing my information (except as necessary to end my participation in the Services) but my revocation will not affect uses and disclosures of my Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that the Patient Support Services may change or end at any time without prior notification. I understand that I have the right to receive a copy of this form.

I agree to be contacted by the Novartis Group by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Service Request Form for all purposes described in this Patient Authorization. I also agree to be contacted by the Novartis Group and on its behalf by telephone calls and text messages made using an automatic telephone dialing system or prerecorded voice, at the number(s) provided on the Service Request Form, 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 e-mail address(es) provided, and I agree to notify the Novartis Group 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.

(continued on page 9)

Patient First Name _____ Patient Last Name _____ Patient Date of Birth _____ Prescriber Name _____ DEA # _____ Tax ID # or NPI # _____

5. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Step 1: Please select product(s)	Step 2: Please indicate which specific support services your patient is interested in receiving (check all that apply)		Step 3: Please fill in the information below
	Patient Support Services	Patient Assistance Program (PAP) for low-income and uninsured patients [†]	
<input type="checkbox"/> Rx: Sandostatin® LAR Depot (octreotide acetate for injectable suspension) Dosage strength (check one) <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 30 mg	<input type="checkbox"/>	<input type="checkbox"/>	ICD/10 _____ Directions: <input type="checkbox"/> Administer _____ mg by intramuscular injection once every 4 weeks (every 28 days) Quantity _____ # of refills authorized _____
<input type="checkbox"/> Rx: SIGNIFOR® LAR (pasireotide) for injectable suspension Dosage strength (check one) <input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg <input type="checkbox"/> 60 mg	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Rx: SIGNIFOR® (pasireotide) injection Dosage strength (check one) <input type="checkbox"/> 0.3 mg <input type="checkbox"/> 0.6 mg <input type="checkbox"/> 0.9 mg	<input type="checkbox"/>	<input type="checkbox"/>	ICD/10 _____ Directions: <input type="checkbox"/> Administer _____ mg by subcutaneous injection twice a day Quantity _____ 30-day supply kit: 60 (1-mL) syringes, 60-18 G long needles, 60-27 G short needles, 60 alcohol swabs, Sharps box. Directions: <input type="checkbox"/> Use as directed For each refill include a 30-day supply kit. Number of refills per shipment _____

[†]Make sure you and your patient sign the Patient Assistance Program Consent on page 2 and that the Patient Financial Information is provided.

<p>Nurse Home Administration for Eligible Sandostatin LAR Depot or SIGNIFOR LAR Patients[‡]:</p> <input type="checkbox"/> Yes, I would like a home health nurse to administer Sandostatin LAR Depot or SIGNIFOR LAR at the patient's home or other location. For _____ visits beginning _____	<p>Injection administered at:</p> <input type="checkbox"/> Patient's home address (see Patient Information on page 2) <input type="checkbox"/> Other (please list street address) _____
<p>[‡]Limitations apply. Available only for patients with commercial insurance. Program not available for patients with Medicare, Medicaid, or any other federal or state program. Program not available for residents of Massachusetts, Michigan, Minnesota, or Rhode Island.</p>	
<p>Self-Injection Home Education for SIGNIFOR patients:</p> <input type="checkbox"/> Yes, I would like the patient to receive education on the administration of SIGNIFOR at the patient's home (see Patient Information on page 2)	

1 PRESCRIBER SIGNATURES

PRESCRIPTION INFORMATION SIGNATURE – REQUIRED FOR ALL PRODUCTS

I certify that I am the health care professional who has prescribed the above therapy to the previously identified patient, that I have made an independent judgment that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents, to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

X _____ — OR — **X** _____
 Prescriber Signature (no stamps) **Dispense as written** Date Prescriber Signature (no stamps) **May substitute** Date

NOTE: DE, NY, and NJ prescribers, or any other state where this is a requirement, must submit a state-approved prescription with this completed form.
 NOTE: Depending on selected programs, additional prescriptions may be required.

(continued from page 7)

I understand that Novartis Pharmaceuticals Corporation 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 e-mail and cell phone cannot be secured against unauthorized access.

D. PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PATIENT (MANDATORY FOR PATIENTS ENROLLING IN THE PATIENT ASSISTANCE PROGRAM)

I give permission for my doctor(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition, and health (“Health Information”) to the Novartis Patient Assistance Foundation, Inc. (the “Foundation”) so that the Foundation can decide if I am eligible for the Novartis Patient Assistance Program (“PAP”); operate the PAP and the Foundation; send me information about PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; ask me for financial, insurance, and/or medical information and share my information as required or permitted by law. I give permission to the Foundation to use information on this Application and any other information I give to the Foundation for these same reasons. I also give the Foundation permission to share my Health Information and other information with people and companies that work with the Foundation; government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my doctor(s) and other people or institutions who are involved in my health care, such as pharmacies and hospitals; other organizations that might help me pay for my medication. I promise that any information, including financial and insurance information that I provide to the Foundation, are complete and true and unless I have said something different in this application, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call the PAP at 1-800-277-2254. I know that the Foundation may change or end the PAP at any time. I know that if I do not sign this form, I will not be able to participate in the PAP, but this will not affect my ability to get medical care, seek payment for this care, or affect my enrollment or eligibility for insurance. I know that I can cancel this permission at any time by calling the PAP at 1-800-277-2254. If I do, then I will not be able to stay in the PAP. I understand that I have the right to receive a copy of this form.