Universal Co-pay Program
Optional Co-pay Assistance Authorization

This form is used by patients to authorize their physician's office to assist with the co-pay assistance process. This form is OPTIONAL. Patients may participate in the co-pay program and obtain co-pay assistance without this form—see Universal Co-pay Program (UCP) Medical Benefit Assistance Request Form for details. If at any time a patient wants to revoke this authorization, he or she may do so by advising the physician's office and calling 1-877-577-7756 to speak with a PANO representative.

1. Fill out Patient Information

2. Read Terms and Conditions below

3. Complete and sign statements below

4. Physician's office staff: scan and upload to portal MedicalCopayClaim.opushealth.com

STEP 1 | **Patient Information (please print)**

Last Name: ____________________ First Name: ____________________

STEP 2 | **Read Terms and Conditions below**

STEP 3 | **Sign Statements below**

I, ______________________, certify that my prescription medication for which I am/will be 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 through my physician's office in connection with this program is/will be accurate to the best of my knowledge, and the medication co-pay expenses for which I am/will be seeking co-pay assistance were/will be 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 page 2 of this document.

Patient Signature: ____________________ Date: ____________

I authorize my physician's office to help me submit documentation required under this program, retain my debit card information, and use co-pay assistance amounts made available under this program to pay my medication co-pay amounts due.

Patient Signature: ____________________ Date: ____________

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

The Novartis Oncology Universal Co-pay Program includes the co-pay card, payment card, or rebate with a combined annual limit of $15,000. 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 patients and is only valid for California patients 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.

Providing the physician fax number will allow the physician to receive faxed updates on status of claims, if available.

Telephone Consumer Protection Act (TCPA) Consent (Optional)

I consent to receive marketing calls and texts from and on behalf of Novartis Pharmaceuticals Corporation, made with an autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. I agree to the TCPA Terms and Conditions. Number of messages will vary based on your program selections. Message and data rates may apply. Text STOP to opt out and HELP for help.

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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.

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.

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