PATIENT | Novartis Oncology Service Request Form

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

Complete the patient Novartis Oncology Service Request Form to find out if you qualify for Novartis Oncology programs that may provide financial support and free trial offers. Your information will be processed in tandem with the information your physician submits on your behalf to finalize the request. It is essential to complete the form in full, including all required fields and authorizations.

Fax Number: 1-888-891-4924

***Required Fields**

Patient Information

First Name*	Last Name*	Date of Birth*	Gender: ☐ Male ☐ Female

Street Address*	City*	State*	Zip Code*

Email	Primary Phone Number*	Other Phone Number

OK to leave detailed voice mail about your medication on your phone* ☐ Yes ☐ No	Designated Contact* ☐ Patient ☐ Patient Caregiver/Advocate ☐ Parent/Legal Guardian

Caregiver/Advocate Name	Caregiver/Advocate Phone
Parent/Legal Guardian Name	Parent/Legal Guardian Phone

Prescription Insurance

Medicare patients please use Medicare Part D information or Part D card. Prescription insurance is often different than medical insurance and is sometimes referred to as PBM or prescription benefit manger and sometimes has its own card.

Prescription Insurance Name	Member ID	Rx Group #	Rx BIN #	Pharmacy Services Phone (see back of card)

Novartis Patient Assistance Foundation

The Novartis Patient Assistance Foundation, Inc., may help provide access to Novartis medicines if you are experiencing financial hardship and/or have no third-party insurance coverage for your medicines.† You may be eligible to receive your Novartis medicine at no cost.†

☐ I do not wish to be considered for the Novartis Patient Assistance Foundation which may provide. medications for free, if eligible.

Financial Documentation Options for verifying income to determine eligibility (Complete one of the following)

1) Check the Fair Credit Reporting Act consent above to allow for electronic income verification

☐ I have read and agree to the Fair Credit Reporting Act (FCRA) on page 4 (Optional)

OR

2) Provide financial documentation as indicated below. Attach a copy of your household's most recent year's tax returns OR 3 months of paycheck stubs OR bank statements OR unemployment checks. Do not send original documents with your form.

Total number of people in the home (Including self)	Total Gross Monthly Household Income: $

US Resident: ☐ Yes ☐ No	Veteran: ☐ Yes ☐ No	Disabled: ☐ Yes ☐ No

Patient Authorization – Required for Processing

I confirm that the information provided herein is truthful and accurate to the best of my knowledge.

☐ I have read and agree to the Telephone Consumer Protection Act (TCPA) on page 4 (Optional)

I have read and agree to the Patient Authorization on page 2-3 on this document. If eligible and unless indicated above, I would like to be considered for the Novartis Patient Assistance Foundation which may provide free access to my medication.

X

Patient/Legal Guardian Signature* | Date

†Please be advised that access to the medicines distributed through the Novartis Patient Assistance Foundation, Inc., is free of charge to all eligible patients. Novartis is not affiliated with any individual or organization that may charge patients a fee(s) to assist them in completing applications for our program. These individuals or organizations are acting independently of the Novartis Patient Assistance Foundation, Inc., and its affiliates and do not have the consent of Novartis.

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, agents, and the Novartis Patient Assistance Foundation, Inc. (collectively, the "Companies") so that the Companies may:

i. help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with the product selected by my HCP,

ii. coordinate my receipt of and payment of the product selected by my HCP,

iii. facilitate my access to the product selected by my HCP

iv. provide me with information about Novartis products, disease education and management programs and promotional materials,

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

vi. provide me with medication reminders and support,

vii. conduct quality assurance, surveys, and other internal business activities in connection with PANO and the Companies and other related programs; and

viii. if I choose to apply to programs offered by the Companies, to administer those programs, to send me information about programs that might help me pay for medicines, and to coordinate or share my Personal Information with my health care providers, other programs that might help me pay for medicines, government agencies, and insurance companies for purposes of providing or facilitating this assistance.

I give permission to the Companies 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 the Companies 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 some of my pharmacies or other health care providers may receive payment from the Companies depending on my enrollment or participation in therapy support services such as prescription refill reminders. 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, the Companies will safeguard 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 1-800-282-7630 or by writing to McKesson, PO Box 29238, Phoenix, AZ 85038-9238. 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 the Companies on an authorized, ongoing basis, my cancellation with the Companies 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 PANO and related programs. If I revoke this authorization, the Companies 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 PANO may change or end at any time without prior notification. I understand that I may receive a copy of this Patient Authorization.

I agree to be contacted by the Companies 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 the Companies, 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 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 and 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.

TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT (OPTIONAL)

I consent to receive marketing calls and texts from and on behalf of the Companies, made with an auto dialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. 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.

TERMS AND CONDITIONS FOR TCPA-RELATED ACTIVITIES

By signing up to receive marketing texts and calls, or by requesting information by telephone, text message, fax, email, direct mail, or other means, you accept, without limitation or qualification, that:

- You and Novartis agree that any legal disputes or claims arising out of or related to the Terms and Conditions, or the use of the Novartis products and/or the Services (including but not limited to telephone calls or text messages sent by Novartis), or the interpretation, enforceability, revocability, or validity of the Terms and Conditions, or the arbitrability of any dispute), that cannot be resolved informally shall be submitted to binding arbitration in the state in which the Terms and Conditions was performed. The arbitration shall be conducted by the American Arbitration Association under its Commercial Arbitration Rules.
- This arbitration clause is an independent agreement and shall survive the termination and/or transfer of these Terms and Conditions or any other agreement between you and Novartis. If any provision of the agreement to arbitrate in this Section is found unenforceable, the

unenforceable provision will be severed and the remaining arbitration terms will be enforced (but in no case will there be a class, representative, or private attorney general arbitration). Any judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Claims shall be brought within the time required by applicable law. The laws of the State of New York will govern the Terms and Conditions and the Federal Arbitration Act, 9 U.S.C. §§ 1-16, will govern this Section, without giving effect to any principles of conflicts of laws. Each party shall bear its own costs relating to the arbitration consistent with the Commercial Arbitration Rules of the American Arbitration Association.

- You and Novartis agree that any claim, action, or proceeding arising out of or related to the Terms and Conditions or telephone calls or text messages sent by Novartis must be brought in your individual capacity, and not as a plaintiff or class member in any purported class, collective, or representative proceeding. The arbitrator may not consolidate more than one person's claims, and the arbitrator may not otherwise preside over any form of a representative, collective, or class proceeding.

YOU ACKNOWLEDGE AND AGREE THAT YOU AND NOVARTIS ARE EACH WAIVING THE RIGHT TO A TRIAL BY JURY OR TO PARTICIPATE AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS ACTION OR REPRESENTATIVE PROCEEDING.

FAIR CREDIT REPORTING ACT (FCRA) AUTHORIZATION (FOR NPAF PROGRAMS ONLY)

I understand that I am providing "written instructions" authorizing the Companies and their vendor, under the FCRA, to obtain information from my credit profile or other information from Experian Health, solely for the purpose of determining financial qualifications for programs administered by the Novartis Patient Assistance Foundation (NPAF). I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information, that I provide are complete and true.

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