Novartis Patient Support™

SCEMBLIX® (asciminib) START FORM

*** = REQUIRED FIELDS**

Novartis Patient Support will provide the following services for eligible patients:

- Novartis Access & Reimbursement Specialist available to HCP/Office Staff
- Insurance Determination & Coverage Review (includes Benefits Verification, Prior Authorization/Appeals research)
- Financial Support (includes Co-Pay Plus, Free Trial Offer)
- Novartis Patient Assistance Foundation, Inc (NPAF)

1. Patient Information

First Name* | Last Name* | Email

Date of Birth (MM/DD/YYYY)* | Sex for Clinical Use*: ☐ Male ☐ Female | ☐ Mobile ☐ Home Phone Number*† — *We'll keep you updated through nonmarketing calls and texts.*

Address (No PO Box)* | OK to Leave Voicemail: ☐ Yes ☐ No

City* | State* | ZIP* | Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

I give permission to disclose my personal health information to the following Caregiver (optional):

Caregiver Name | Relationship to Patient

Caregiver Phone Number — *We'll keep you updated through nonmarketing calls and texts.*

2. Patient Authorization and Additional Enrollment Consents

I have read and agree to the Patient Authorization on page 3.

X _____ / / _____

Patient/Authorized Representative* Signature | **Date (MM/DD/YYYY)**

☐ Check here if signed by an Authorized Representative.

CO-PAY PLUS‡

Pay as little as $0 per month

☐ I have read and agree to the Co-Pay Plus Terms and Conditions on page 3.

ONGOING SUPPORT FROM NOVARTIS PATIENT SUPPORT

You can also get continued one-on-one support from your dedicated Novartis Patient Support Team by checking the box below.

☐ I agree to receive marketing calls and texts from and on behalf of Novartis and its affiliates, including calls and texts made with an autodialer or prerecorded voice, at the phone number(s) I provide. I understand that my consent is not required and is not a condition of receiving any goods or services from Novartis.

3. Insurance Information

Please include copies (front and back)* of the patient's medical and prescription insurance card(s). Include primary, and secondary, and prescription insurance.

Check all that apply*: ☐ Primary ☐ Secondary ☐ Prescription ☐ Patient Is Uninsured

4. Prescriber Information

First Name* | Last Name* | Practice Name*

Address | Practice Phone Number

City | State | ZIP* | Office Contact Name* | Office Contact Phone*

Prescriber NPI Number* | Office Fax*

Tax ID Number | State License Number | Office Contact Email

Send Fax
800-368-5564

Questions? Call
866-433-8000

Complete entire form and fax to Novartis Patient Support at 800-368-5564.
An incomplete Start Form may delay the start of treatment.

Patient Name* _____ Date of Birth (MM/DD/YYYY)* ___/___/___

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5. Prescription Information

Preferred Specialty Pharmacy: ☐ Onco360 ☐ Biologics ☐ Other (please fill out information)

If "Other" was selected, please indicate the patient's Preferred Specialty Pharmacy information below:

Preferred Specialty Pharmacy	Preferred Specialty Pharmacy Phone Number	Preferred Specialty Pharmacy Fax Number

Primary Diagnosis Code*:

☐ C92.10 Chronic myeloid leukemia, BCR::ABL-positive, not having achieved remission

☐ C92.11 Chronic myeloid leukemia, BCR::ABL-positive, in remission

☐ C92.12 Chronic myeloid leukemia, BCR::ABL-positive, in relapse

☐ Other: _____

Please check a single box in each applicable column:

Product Information	Recommended Dosage	Quantity	Refills
SCEMBLIX: ☐ **20 mg tablet** ☐ **40 mg tablet**	☐ 80 mg orally once daily ☐ 40 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX: (Dosage reductions) ☐ **20 mg tablet** ☐ **40 mg tablet**	☐ 40 mg orally once daily ☐ 20 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX: (for T315I mutation) ☐ **20 mg tablet** ☐ **40 mg tablet** ☐ **100 mg tablet**	☐ 200 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills

Prescriber Attestation

I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the prescriber who has prescribed SCEMBLIX to the patient named on this form. I certify that any medication received from Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") or the Novartis Patient Assistance Foundation, Inc, and its service providers ("NPAF"), will be used only for the patient named on this form and will not be offered for sale, trade, or barter, returned for credit, or submitted for reimbursement in any form. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Novartis and NPAF may revise, change, or terminate their respective programs at any time.

I have discussed the Novartis Patient Support Program with my patient, who has authorized me under HIPAA and state law to disclose their information to Novartis for the limited purpose of enrolling in Novartis Patient Support. To complete this enrollment, Novartis may contact the patient by phone, text, and email.

→ **X** _____ _____ _____ ___/___/___

Prescriber Signature (Dispense as Written) **(Substitution Permissible)** **Prescriber Name (Print Name)*** **Date (MM/DD/YYYY)***

ATTN: Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).

Send Fax 800-368-5564

Questions? Call 866-433-8000

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Novartis Patient Support

Patient Authorization

I authorize my health care providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment, and prescription details ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") and the Novartis Patient Assistance Foundation, Inc, and its service providers ("NPAF") so they can provide the following support services (the "Services"):

- Help coordinate insurance coverage for, access to, and receipt of my medication.
- Communicate with me about possible financial assistance, including Novartis copay or NPAF programs, and, if I am enrolled, administer my participation in those programs.
- Communicate with me about my medication and treatment, including reminders, health and lifestyle tips, and product and other related information. Communications may be customized based on Personal Information obtained from my Providers.
- Conduct quality assurance and other internal business activities and ask for feedback related to the Services or my treatment.

In delivering the Services, Novartis and NPAF may share my Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with information collected from other sources and use that information to administer the Services. My pharmacies or other health care providers may receive payment from Novartis or NPAF for providing certain Services, such as medication or refill reminders, based on my enrollment or participation. Once I authorize disclosure of my Personal Information, it may no longer be protected by federal health privacy law and applicable state laws.

I understand I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling 866-433-8000 or by writing to:

Novartis Patient Support
Novartis Pharmaceuticals Corporation
One Health Plaza
East Hanover, NJ 07936-1080

This Authorization will expire 5 years after I sign it, or earlier if required by state law, unless I cancel it sooner. If I cancel it, I may no longer qualify for Services from Novartis or NPAF, but it will not impact my Provider's treatment or my insurance benefits. I also understand that if a Provider is disclosing my Personal Information to Novartis or NPAF on an authorized, ongoing basis, my cancellation will be effective with respect to that Provider as soon as they receive notice of my cancellation. Cancellation will not affect prior uses or disclosures.

‡**Co-Pay Plus Terms and Conditions**
Limitations apply. Valid only for those with private insurance. The Program includes the Co-Pay Plus offer, Plus Card (if applicable), and Rebate, with a combined annual limit up to $15,000. Patient is responsible for any costs once limit is reached in a calendar year. Program not valid (i) under Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program, (ii) where patient is not using insurance coverage at all, (iii) where the patient's insurance plan 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 patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles. Program is not valid where prohibited by law. 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 their health plan related to the use of the Program. Valid only in the United States and Puerto Rico. This Program is not health insurance. Program may not be combined with any third-party rebate, coupon, or offer. Proof of purchase may be required. Novartis reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

†Novartis Patient Support may call and text you at the numbers provided for non-marketing purposes (e.g., to help you access and start on SCEMBLIX). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 866-433-8000.

Please see the Novartis Pharmaceuticals Corporation Privacy Policy at http://www.novartis.com/us-en/privacy.

NOVARTIS

SCEMBLIX® (asciminib) 20 mg, 40 mg tablets