

New York prescribers please note: The COSENTYX® Connect Personal Support Program or the Network Specialty Pharmacy will contact you to submit your eRX as they are needed.

## 1. PATIENT INFORMATION (Section 1 to be completed and signed by patient)

Patient's Name (First, MI, Last) \_\_\_\_\_  
 DOB (MM/DD/YYYY) \_\_\_\_\_ Sex:  M  F  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 E-mail (optional) \_\_\_\_\_  
 I have read and agree to the Terms and Conditions for participation in the COSENTYX® Co-pay Assistance Program on page 3.

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
 OK to leave message about COSENTYX® on:  Cell Phone  Home Phone  
 Preferred Language:  English  Spanish  Other \_\_\_\_\_  
 Alternate Contact Name \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 If eligible, I would like to be connected with the Patient Assistance Program (PAP) application process. (optional)

### PATIENT/LEGAL GUARDIAN SIGNATURE

(required) I have read and agree to the Patient Authorization on pages 2 and 3. Date (MM/DD/YYYY)

## 2. INSURANCE INFORMATION (Section 2 to be completed by patient)

Beneficiary/Cardholder Name \_\_\_\_\_  
 Primary Insurance \_\_\_\_\_ Phone # \_\_\_\_\_  
 Primary Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

Prescription Insurance \_\_\_\_\_ ID # \_\_\_\_\_  
 Rx Group # \_\_\_\_\_ Rx BIN # \_\_\_\_\_ Rx PCN # \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

### FOR HEALTHCARE PROVIDER USE ONLY

## 3. PRESCRIBER INFORMATION (Sections 3-7 to be completed by the prescriber)

Prescriber's Name (First, Last) \_\_\_\_\_  
 Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_  
 Office Contact Name \_\_\_\_\_  
 Office E-mail (optional) \_\_\_\_\_

Tax ID # \_\_\_\_\_ NPI # \_\_\_\_\_  
 Site Institution Name (optional) \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## 4. CLINICAL INFORMATION

### PRIMARY DIAGNOSIS/ICD-10 Codes: (check all that apply)

L40.00: (Plaque psoriasis)  M45.0: (Ankylosing spondylitis)  
 L40.50: (Arthropathic psoriasis, unspecified)  Other ICD-10 Code(s): \_\_\_\_\_  
 L40.59: (Other psoriatic arthropathy)

Has patient participated in a COSENTYX clinical trial?  YES  NO  
 The patient has previously been treated with a biologic for the diagnosed condition.  YES  NO  
 If patient has been treated with a biologic, please answer the following questions.  
 Does this patient have a contraindication, intolerance, or allergy to Enbrel®, Humira®, Remicade®, Stelara®, Cimzia®, Simponi®, Taltz®, or other biologic treatment?  YES  NO

Does this patient have documented efficacy failure of adequate trial on Enbrel®, Humira®, Remicade®, Stelara®, Cimzia®, Simponi®, Taltz®, or other biologic treatment?  YES  NO

If YES, please indicate which drug(s) and date(s) of usage.  
 Enbrel® From: \_\_\_\_\_ To: \_\_\_\_\_ Humira® From: \_\_\_\_\_ To: \_\_\_\_\_  
 Remicade® From: \_\_\_\_\_ To: \_\_\_\_\_ Stelara® From: \_\_\_\_\_ To: \_\_\_\_\_  
 Cimzia® From: \_\_\_\_\_ To: \_\_\_\_\_ Simponi® From: \_\_\_\_\_ To: \_\_\_\_\_  
 Taltz® From: \_\_\_\_\_ To: \_\_\_\_\_ Other \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

## 5. SHIPPING PREFERENCES and INJECTION TRAINING

FIRST DOSE:  Prescriber Address  Patient Address  
 FOLLOW-UP DOSES:  Prescriber Address  Patient Address  
 I also request supplemental injection training for this patient.

## 6. COVERED UNTIL YOU'RE COVERED\* FREE MEDICATION PRESCRIPTION (optional)

Covered Until You're Covered Program: Eligible patients must have commercial insurance, a valid prescription for COSENTYX, and a denial of insurance coverage based on a prior authorization request. Program requires the submission of an appeal within 90 days after enrollment. Please complete the full Service Request Form, including steps 1-4 below and sign. See Program Terms and Conditions on Page 3.

## 7. NETWORK PHARMACY PRESCRIPTION (Please complete steps 1-4 below and sign)

Preferred Specialty Pharmacy (optional): \_\_\_\_\_

STEP 1:  SENSOREADY® PEN  OR  PREFILLED SYRINGE  
 STEP 2:  Inject 300-mg dose subcutaneously (2 injections of 150 mg)  OR  Inject 150-mg dose subcutaneously  
 STEP 3: INITIAL WEEKLY LOADING DOSE? (Weeks 0, 1, 2, 3, and 4)  YES  NO  
 STEP 4: # OF MONTHLY REFILLS? (once every 4 weeks) \_\_\_\_\_

### PRESCRIBER CERTIFICATION

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed COSENTYX to the previously identified patient and that I provided the patient with a description of the COSENTYX Connect Personal Support Program. I authorize the COSENTYX Connect Personal Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

### PRESCRIBER SIGNATURE

(required) (No Stamp Allowed) Date (MM/DD/YYYY)

STEP 1:  SENSOREADY® PEN  OR  PREFILLED SYRINGE  
 STEP 2:  Inject 300-mg dose subcutaneously (2 injections of 150 mg)  OR  Inject 150-mg dose subcutaneously  
 STEP 3: INITIAL WEEKLY LOADING DOSE? (Weeks 0, 1, 2, 3, and 4)  YES  NO  
 STEP 4: # OF MONTHLY REFILLS? (once every 4 weeks) \_\_\_\_\_

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I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed COSENTYX to the previously identified patient and that I provided the patient with a description of the COSENTYX Connect Personal Support Program. I authorize the COSENTYX Connect Personal Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy. I understand that the Covered Until You're Covered Program is designed to support patients who are denied insurance coverage for COSENTYX for up to two years until such coverage is secured, and I confirm that I will support the above identified patient in seeking to secure such coverage as I deem appropriate.

### PRESCRIBER SIGNATURE

(required) (No Stamp Allowed) Date (MM/DD/YYYY)

*Please read the following carefully, then sign and date where indicated on page 1.*

## **Patient Authorization**

I give permission for my healthcare providers (HCPs), pharmacies, health insurer(s), third-party contractors, and 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, and agents (together, the “Novartis Group”) so that the Novartis Group can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with COSENTYX, (ii) coordinate my receipt of, and payment for COSENTYX, (iii) facilitate my access to COSENTYX, (iv) provide me with information about COSENTYX, disease awareness and management programs, and educational materials, (v) manage the COSENTYX Connect Personal Support Program, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the COSENTYX Connect Personal Support Program.

I give permission to the Novartis Group to disclose my Personal Information to my HCPs, 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 healthcare providers may receive remuneration (payment) from 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 COSENTYX Connect Personal Support Program. If I revoke this authorization, the Novartis Group 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 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 COSENTYX Connect Personal Support Program may change or end at any time without prior notification. I understand that I may receive a copy of this authorization. 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.

(continued on last page)

I also agree to be contacted by the Novartis Group and on its behalf by telephone calls and text messages made by 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.

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.

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### **Co-pay Assistance Program Terms and Conditions**

I understand that this offer is only valid for those with commercial insurance and who have a valid prescription. I understand that this offer is not valid under Medicare, Medicaid, or any other federal or state program (eg, VA, DoD, Tricare), for cash-paying patients, where product is not covered by patient's commercial insurance, or where the plan reimburses the patient for the entire cost of his/her prescription drug. I also understand that this offer is not valid where prohibited by law and is only valid in the United States and Puerto Rico. Finally, Novartis requires patients to annually re-enroll and re-attest to the program terms and conditions. We may use the information you provide to contact you to remind you that your co-pay assistance is about to expire and to confirm your eligibility to continue participating in co-pay assistance.

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### **\*Covered Until You're Covered Program Terms and Conditions**

Eligible patients must have commercial insurance, a valid prescription for COSENTYX, and a denial of insurance coverage based on a prior authorization request. Program requires the submission of an appeal of the coverage denial within the first 90 days of enrollment in order to remain eligible. Program provides initial 5 weekly doses (if prescribed) and monthly doses for free to patients for up to two years or until they receive insurance coverage approval, whichever occurs earlier. Program is not available to patients whose medications are reimbursed in whole or in part by Medicare, Medicaid, Tricare, or any other federal or state program. Patients may be asked to re-verify insurance coverage status during the course of the program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Limitations may apply. Enrolled patients awaiting coverage for COSENTYX after two years may be eligible for a limited Program extension. Novartis Pharmaceuticals Corporation reserves the right to rescind, revoke, or amend this Program without notice. Program enrollment must occur by 12/31/18.