Cosentyx® (secukinumab)

2021 UPDATE

SERVICE REQUEST FORM (SRF), PRESCRIPTIONS, AND COSENTYX® CONNECT PATIENT SUPPORT ENROLLMENT FORM

All fields required, unless noted.

PHONE: 1-844-267-3689
FAX: 1-844-666-1366 or 1-800-343-9117
Include copy of the insurance card(s) (front and back) and complete all the information below.

1. PATIENT INFORMATION *(Section 1 to be completed and signed by patient or Parent/Legal Guardian)*

REQUIRED

Patient's Name (First, MI, Last) _____
DOB (MM/DD/YYYY) _____ Sex: ☐ M ☐ F
Street Address _____
City _____ State _____ ZIP _____
Cell Phone _____
Home Phone _____

Patient Authorization (required)
I confirm that the information provided herein is truthful and accurate to the best of my knowledge.
☐ **I have read and agree to the Terms and Conditions for the Co-pay Assistance Program on page 3.**
I have read and agree to the Patient Authorization on page 2.

PATIENT/LEGAL GUARDIAN SIGNATURE & DATE
Legal signature **Date (MM/DD/YYYY)**
CANNOT PROCESS FORM WITHOUT SIGNATURE AND DATE

Contact Email (required for co-pay enrollment) _____
OK to leave message about COSENTYX® on: ☐ Cell Phone ☐ Home Phone ☐ Authorized Contact
Preferred Language: ☐ English ☐ Spanish ☐ Other _____
Authorized Contact/Parent/Legal Guardian Name _____
Relationship to Patient _____
Contact Phone _____

The COSENTYX® Connect program includes calls and texts to help you get started on COSENTYX. After you fill your prescription, you will receive reminders, education, and lifestyle tips by mail and email. You can also get this ongoing support via calls and texts by checking the box below.

☐ **I agree to receive recurring reminders, tips, and more via calls and texts at the phone number provided. I understand calls or texts may be autodialed or prerecorded and are not a condition of purchase**

Novartis Patient Assistance Foundation, Inc. (NPAF) provides free COSENTYX to eligible uninsured and underinsured patients. Proof of income is required. If you choose to apply for free medication, checking the box below will prompt NPAF to verify your income.

☐ **I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization on page 3.**

REQUIRED

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

Please check appropriate box: ☐ Insured ☐ Uninsured
Prescription Insurance _____ ID# _____
Rx Group # _____ Rx BIN # _____ Rx PCN # _____
Beneficiary/Cardholder Name _____

Primary Health Insurance _____ Phone # _____
Primary Health Insurance ID # _____ Group # _____
Secondary Health Insurance _____ ID # _____ Group # _____

FOR HEALTHCARE PROVIDER USE ONLY

3. PRESCRIBER INFORMATION *(Sections 3–7 to be completed by the prescriber)* REQUIRED EXCEPT WHERE NOTED

Prescriber's Name (First, Last) _____ NPI # _____
Office Phone _____ Office Fax _____ Site Institution Name (optional) _____
Office Contact Name _____ Address _____
Office Email (optional) _____ City _____ State _____ ZIP _____

4. CLINICAL INFORMATION

PRIMARY DIAGNOSIS/ICD-10-CM Codes: (check one) – **REQUIRED**

☐ L40.00: (Plaque psoriasis)
☐ L40.50: (Arthropathic psoriasis, unspecified)
☐ L40.59: (Other psoriatic arthropathy)
☐ M45.0: (Ankylosing spondylitis)
☐ M46.80: (Non-radiographic axial spondyloarthritis)
☐ Other ICD-10-CM Code(s): _____

Secondary Diagnosis/Special Areas or Manifestations (optional) _____

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 or another therapy, please answer the following questions

Excluding COSENTYX, does this patient have a contraindication, intolerance, or allergy to Cimzia®, Enbrel®, Humira®, Remicade®, Simponi®, Stelara®, Taltz®, or other biologic treatments, or to Phototherapy, Methotrexate, Sulfasalazine, NSAIDs (diclofenac, ibuprofen, etc)? ☐ Yes _____ ☐ No

Excluding COSENTYX, does this patient have documented efficacy failure of adequate trial on NSAIDs, DMARDs, or other treatments?
☐ Yes ☐ No

If YES, please indicate which drug(s):

☐ Cimzia® ☐ Enbrel® ☐ Humira® ☐ Otezla®
☐ Remicade® ☐ Rinvoq™ ☐ Simponi® ☐ Skyrizi®
☐ Stelara® ☐ Taltz® ☐ Tremfya® ☐ Other _____
☐ Phototherapy ☐ Methotrexate ☐ Sulfasalazine ☐ NSAIDs (diclofenac, ibuprofen, etc)

5. SUPPLEMENTAL INJECTION DEMONSTRATION *(Optional)*

Prescriber confirms in-office injection training will be provided.
☐ Request supplemental in-home injection demonstration for patient
☐ Request supplemental virtual injection demonstration for patient

7. NETWORK PHARMACY PRESCRIPTION *(Please complete steps 1–4 below and sign)*

HCP Preferred Specialty Pharmacy (optional): _____
☐ The patient prescription has been sent to the specialty pharmacy noted above

REQUIRED

STEP 1: ☐ **SENSOREADY® PEN (150 mg only)** OR ☐ **PREFILLED SYRINGE (150 mg or 75 mg)**

STEP 2: ☐ **Inject 300 mg dose subcutaneously (2x 150 mg/mL)** OR ☐ **Inject 150 mg/mL dose subcutaneously** OR ☐ **Inject 75 mg/0.5 mL 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)? _____

FIRST DOSE SHIPPING: ☐ Prescriber Address ☐ Patient Address
ALL SUBSEQUENT DOSES WILL BE SHIPPED TO THE PATIENT

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.

REQUIRED

I agree to the NPAF Authorization on page 3. I also agree to receive communications, including faxes, related to my patient's enrollment or participation in the COSENTYX® Connect Personal Support Program.

PRESCRIBER SIGNATURE & DATE
(No Stamp Allowed) **Date (MM/DD/YYYY)**
CANNOT PROCESS FORM WITHOUT SIGNATURE AND DATE

6. COVERED UNTIL YOU'RE COVERED FREE MEDICATION PRESCRIPTION

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.**

STEP 1: ☐ **SENSOREADY® PEN (150 mg only)** OR ☐ **PREFILLED SYRINGE (150 mg or 75 mg)**

STEP 2: ☐ **Inject 300 mg dose subcutaneously (2x 150 mg/mL)** OR ☐ **Inject 150 mg/mL dose subcutaneously** OR ☐ **Inject 75 mg/0.5 mL 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)? _____

FIRST DOSE SHIPPING: ☐ Prescriber Address ☐ Patient Address
ALL SUBSEQUENT DOSES WILL BE SHIPPED TO THE PATIENT

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. 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 2 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.

I also agree to receive communications, including faxes, related to my patient's enrollment or participation in the COSENTYX® Connect Personal Support Program.

REQUIRED

PRESCRIBER SIGNATURE & DATE
(No Stamp Allowed) **Date (MM/DD/YYYY)**
CANNOT PROCESS FORM WITHOUT SIGNATURE AND DATE

New York prescribers please note: The COSENTYX® Connect Personal Support Program or the Network Specialty Pharmacy will contact you to submit your electronic prescription (eRx) as needed.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

5/21 T-COS-1401322

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

Patient Authorization

I authorize my healthcare 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 co-pay 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 healthcare providers may receive payment from Novartis or NPAF for providing certain aspects of the 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 that I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and I can cancel this Authorization at any time by calling 1-844-267-3689 or writing to

Cosentyx Connect Patient Support Program
PO Box 2953,
Phoenix, AZ 85062-2953

or

Customer Interaction Center
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 Providers' 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.

I agree for myself and certify (if applicable) that my caregiver agrees to receive nonmarketing calls and texts from Novartis or NPAF, including through an autodialer or prerecorded voice, at the number(s) provided.

Please visit the Novartis Website: https://www.pharma.us.novartis.com

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

Co-pay Assistance Program Terms and Conditions

Limitations apply. Valid only for those with private insurance. The COSENTYX Co-pay Program includes the Co-pay Card, Payment Card (if applicable), and Rebate, with a combined annual limit up to $16,000. 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 healthcare 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 healthcare 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 US 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.

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 reverify 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.

Fair Credit Reporting Act (FCRA) Authorization

I understand that I am providing "written instructions" authorizing the Novartis Patient Assistance Foundation (NPAF) and its vendors, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for programs administered by NPAF. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process.

Novartis Patient Assistance Foundation (NPAF) Authorization FOR PHYSICIAN

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge. I certify that I am the physician who has prescribed the drug identified above to the previously identified patient. For the purposes of transmitting this prescription, I authorize NPAF and its affiliates, business partners, and agents to forward as my agent for these limited purposes this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Further, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that NPAF may revise, change, or terminate programs at any time.

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

Cosentyx® (secukinumab)

2021 UPDATE **EXAMPLE FORM**

SERVICE REQUEST FORM (SRF), PRESCRIPTIONS, AND COSENTYX® CONNECT PATIENT SUPPORT ENROLLMENT FORM

All fields required, unless noted.

PHONE: 1-844-267-3689
FAX: 1-844-666-1366 or 1-800-343-9117
Include copy of the insurance card(s) (front and back) and complete all the information below.

1. PATIENT INFORMATION *(Section 1 to be completed and signed by patient or Parent/Legal Guardian)*

REQUIRED

Patient's Name (First, MI, Last): Jane A. Doe
DOB (MM/DD/YYYY): 09/27/1963 Sex: ☑ M ☐ F
Street Address: 1246 Hanson Way
City: Raleigh State: NC ZIP: 23645
Cell Phone: 919-123-5555
Home Phone: 919-123-4567

Patient Authorization (required)
I confirm that the information provided herein is truthful and accurate to the best of my knowledge.
☑ **I have read and agree to the Terms and Conditions for the Co-pay Assistance Program on page 3.**
I have read and agree to the Patient Authorization on page 2.

PATIENT/LEGAL GUARDIAN SIGNATURE & DATE
Jane Doe — **Legal signature**
01/15/2020 — **Date (MM/DD/YYYY)**
CANNOT PROCESS FORM WITHOUT SIGNATURE AND DATE

Contact Email (required for co-pay enrollment): JDoe@yahoo.com
OK to leave message about COSENTYX® on: ☑ Cell Phone ☐ Home Phone ☐ Authorized Contact
Preferred Language: ☑ English ☐ Spanish ☐ Other
Authorized Contact/Parent/Legal Guardian Name: Jen B. Sample
Relationship to Patient: Parent
Contact Phone: 919-321-5555

The COSENTYX® Connect program includes calls and texts to help you get started on COSENTYX. After you fill your prescription, you will receive reminders, education, and lifestyle tips by mail and email. You can also get this ongoing support via calls and texts by checking the box below.
☑ **I agree to receive recurring reminders, tips, and more via calls and texts at the phone number provided. I understand calls or texts may be autodialed or prerecorded and are not a condition of purchase**

Novartis Patient Assistance Foundation, Inc. (NPAF) provides free COSENTYX to eligible uninsured and underinsured patients. Proof of income is required. If you choose to apply for free medication, checking the box below will prompt NPAF to verify your income.
☑ **I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization on page 3.**

REQUIRED

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

Please check appropriate box: ☑ Insured ☐ Uninsured
Prescription Insurance: Express Scripts ID#: W12345678
Rx Group #: 12345 Rx BIN #: 987654 Rx PCN #: 6789
Beneficiary/Cardholder Name: Jane A. Doe

Primary Health Insurance: Blue Cross Blue Shield Phone #: 1-866-966-5777
Primary Health Insurance ID #: YPYW12345678 Group #: 12345
Secondary Health Insurance: Aetna ID #: 12345 Group #: 12345

FOR HEALTHCARE PROVIDER USE ONLY

3. PRESCRIBER INFORMATION *(Sections 3–7 to be completed by the prescriber)* REQUIRED EXCEPT WHERE NOTED

Prescriber's Name (First, Last): John Doe, MD
Office Phone: 919-333-5323 Office Fax: 919-212-1221
Office Contact Name: Beth Dunn
Office Email (optional): BDunn@RaleighDerm.com

NPI #: 123456789
Site Institution Name (optional): Raleigh Dermatology
Address: 1468 Raleigh Rd.
City: Raleigh State: NC ZIP: 27529

4. CLINICAL INFORMATION

PRIMARY DIAGNOSIS/ICD-10-CM Codes: (check one) – **REQUIRED**

☐ L40.00: (Plaque psoriasis)
☑ L40.50: (Arthropathic psoriasis, unspecified)
☐ L40.59: (Other psoriatic arthropathy)
☐ M45.0: (Ankylosing spondylitis)
☐ M46.80: (Non-radiographic axial spondyloarthritis)
☐ Other ICD-10-CM Code(s):

Secondary Diagnosis/Special Areas or Manifestations (optional) Nail, PsA, & axial involvement

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 or another therapy, please answer the following questions

Excluding COSENTYX, does this patient have a contraindication, intolerance, or allergy to Cimzia®, Enbrel®, Humira®, Remicade®, Simponi®, Stelara®, Taltz®, or other biologic treatments, or to Phototherapy, Methotrexate, Sulfasalazine, NSAIDs (diclofenac, ibuprofen, etc)? ☐ Yes ☑ No

Excluding COSENTYX, does this patient have documented efficacy failure of adequate trial on NSAIDs, DMARDs, or other treatments?
☑ Yes ☐ No

If YES, please indicate which drug(s):

☐ Cimzia® ☐ Enbrel® ☐ Humira® ☐ Otezla®
☐ Remicade® ☐ Rinvoq™ ☐ Simponi® ☐ Skyrizi®
☐ Stelara® ☐ Taltz® ☐ Tremfya® ☐ Other
☑ Phototherapy ☑ Methotrexate ☐ Sulfasalazine ☐ NSAIDs (diclofenac, ibuprofen, etc)

5. SUPPLEMENTAL INJECTION DEMONSTRATION *(Optional)*

Prescriber confirms in-office injection training will be provided.
☐ Request supplemental in-home injection demonstration for patient
☑ Request supplemental virtual injection demonstration for patient

7. NETWORK PHARMACY PRESCRIPTION *(Please complete steps 1–4 below and sign)*

HCP Preferred Specialty Pharmacy (optional): Specialty Pharmacy X
☐ The patient prescription has been sent to the specialty pharmacy noted above

REQUIRED

STEP 1: ☑ **SENSOREADY® PEN (150 mg only)** OR ☐ **PREFILLED SYRINGE (150 mg or 75 mg)**
STEP 2: ☑ **Inject 300 mg dose subcutaneously (2x 150 mg/mL)** OR ☐ **Inject 150 mg/mL dose subcutaneously** OR ☐ **Inject 75 mg/0.5 mL 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)? 3
FIRST DOSE SHIPPING: ☑ Prescriber Address ☐ Patient Address
ALL SUBSEQUENT DOSES WILL BE SHIPPED TO THE PATIENT

REQUIRED

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.

REQUIRED

I agree to the NPAF Authorization on page 3. I also agree to receive communications, including faxes, related to my patient's enrollment or participation in the COSENTYX® Connect Personal Support Program.

PRESCRIBER SIGNATURE & DATE
Dr. John Doe — **(No Stamp Allowed)**
01/15/2020 — **Date (MM/DD/YYYY)**
CANNOT PROCESS FORM WITHOUT SIGNATURE AND DATE

6. COVERED UNTIL YOU'RE COVERED FREE MEDICATION PRESCRIPTION

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.**

STEP 1: ☑ **SENSOREADY® PEN (150 mg only)** OR ☐ **PREFILLED SYRINGE (150 mg or 75 mg)**
STEP 2: ☑ **Inject 300 mg dose subcutaneously (2x 150 mg/mL)** OR ☐ **Inject 150 mg/mL dose subcutaneously** OR ☐ **Inject 75 mg/0.5 mL 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)? 3
FIRST DOSE SHIPPING: ☑ Prescriber Address ☐ Patient Address
ALL SUBSEQUENT DOSES WILL BE SHIPPED TO THE PATIENT

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. 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 2 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.

I also agree to receive communications, including faxes, related to my patient's enrollment or participation in the COSENTYX® Connect Personal Support Program.

REQUIRED

PRESCRIBER SIGNATURE & DATE
Dr. John Doe — **(No Stamp Allowed)**
01/15/2020 — **Date (MM/DD/YYYY)**
CANNOT PROCESS FORM WITHOUT SIGNATURE AND DATE

New York prescribers please note: The COSENTYX® Connect Personal Support Program or the Network Specialty Pharmacy will contact you to submit your electronic prescription (eRx) as needed.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

5/21 T-COS-1401322