Cosentyx® (secukinumab)

**2019 UPDATE**

# SERVICE REQUEST FORM (SRF) AND PRESCRIPTIONS

*All fields required, unless noted.*

**PHONE: 1-844-267-3689**
**FAX: 1-844-666-1366**

***Include copy of the insurance card(s) (front and back) and complete all the information below.***

**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 (required) ____________________

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 ____________________

**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 4.

☐ I have read and agree to the Telephone Consumer Protection Act (TCPA) Consent on page 3. (Optional)

I have read and agree to the Patient Authorization on pages 2 and 3.

If eligible and unless indicated below, I would like to be considered for the Novartis Patient Assistance Foundation (NPAF), which may provide free access to my medication, and if my income or health coverage changes, I will call NPAF at 1-800-277-2254.

☐ I do not wish to be considered for NPAF, which may provide medications for free.

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

**PATIENT/LEGAL GUARDIAN SIGNATURE** ____________________ **Date (MM/DD/YYYY)**

**CANNOT PROCESS FORM WITHOUT THIS COMPLETED**

## 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 # __________

## 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 __________

☐ Request supplemental injection demo for this patient (Prescriber will provide initial training)

## 4. CLINICAL INFORMATION

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

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

**Secondary Diagnosis** (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, 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.**

| Drug | From | To | Drug | From | To |
|---|---|---|---|---|---|
| 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

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

**Preferred Specialty Pharmacy (recommended):** ____________________

**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.

I agree to the NPAF Authorization on page 4. 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** ____________________

**CANNOT PROCESS FORM WITHOUT THIS COMPLETED** (No Stamp Allowed) Date (MM/DD/YYYY)

## 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 4.**

**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. 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.

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** ____________________

**CANNOT PROCESS FORM WITHOUT THIS COMPLETED** (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, service providers and their contractors (“Healthcare 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 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 COSENTYX (Secukinumab), **ii)** coordinate my receipt of and payment for COSENTYX, **iii)** facilitate my access to COSENTYX, **iv)** provide me with information about Novartis products, disease education and management programs, and promotional materials, **v)** if I am eligible, coordinate the COSENTYX Co-pay Program, including managing and communicating with me about the copay support options available to me, **vi)** provide me with medication reminders and support, and **vii)** conduct quality assurance, surveys, and other internal business activities in connection with the COSENTYX Connect Personal Support Program and other related programs, and **viii)** if I choose to apply to programs offered by Novartis Patient Assistance Foundation, Inc., 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 Healthcare Providers, other programs that might help me pay for medicines, government agencies, and insurance of providing or facilitating this assistance.

I give permission to the Companies to disclose my Personal Information to my Healthcare 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 and NPAF 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 Healthcare 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.

(continued on next page)

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 1-844-267-3689 or by writing to McKesson, PO Box 2953, Phoenix, AZ 85062-2953.

If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Healthcare 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 Healthcare 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 COSENTYX Connect Personal Support Program 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 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 Patient Authorization.

I agree to be contacted by the Companies by mail, e-mail, 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 e-mail address(es) provided, and I agree to notify the Companies 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 e-mail and cell phone cannot be secured against unauthorized access.

## Telephone Consumer Protection Act (TCPA) Consent

I consent to receive marketing calls and texts from and on behalf of Novartis Pharmaceuticals Corporation and NPAF, 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.

## 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 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 12/31/19.

## Fair Credit Reporting Act (FCRA) Authorization

I understand that I am providing "written instructions" authorizing 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

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