NOVARTIS SERVICE REQUEST FORM FOR PATIENT SUPPORT

Please complete the Fax Cover Sheet and Service Request Form, and fax all pages to the number specified below.

Dear Health Care Professional:

The Novartis Service Request Form helps assess patient eligibility for all Novartis access programs. It is therefore essential to complete the enclosed enrollment form in full. Without a fully completed form, service may be delayed while we obtain any missing information.

To: _____ (Novartis Patient Support or the selected Specialty Pharmacy)	**Fax Number:** _____ For ZYKADIA, please fax ALL PAGES (8) to selected pharmacy on page 5. For all other prescriptions, please fax ALL PAGES (8) to **1-888-891-4924**.

Please select product(s):

- ☐ AFINITOR® (everolimus) Tablets
- ☐ VOTRIENT® (pazopanib) tablets
- ☐ Sandostatin® LAR Depot (octreotide acetate for injectable suspension)
- ☐ GLEEVEC® (imatinib mesylate) tablets
- ☐ TASIGNA® (nilotinib) capsules
- ☐ JADENU™ (deferasirox) tablets
- ☐ EXJADE® (deferasirox) tablets for oral suspension
- ☐ ZYKADIA™ (ceritinib) capsules
- ☐ FARYDAK® (panobinostat) capsules
- ☐ TAFINLAR® (dabrafenib) capsules
- ☐ MEKINIST® (trametinib) tablets
- ☐ PROMACTA® (eltrombopag) tablets
- ☐ TYKERB® (lapatinib) tablets
- ☐ ARZERRA® (ofatumumab) Injection, for intravenous infusion

Please indicate which specific services your patient is interested in receiving from the list below:

- ☐ Benefit investigation
- ☐ Prior authorization
- ☐ Assistance with denials/appeals
- ☐ Therapy-specific support programs for out-of-pocket costs
- ☐ Patient Assistance Program (PAP) for low-income and uninsured patients

Follow the steps below to complete the Service Request Form, and please check the areas you have completed

☐ **Patient Information (Section 1)**
Complete with all relevant information. Be sure to have the patient sign the **Patient Authorization** and the **Patient Assistance Program (PAP) Consent For Patient** (if applicable). For ZYKADIA specialty pharmacy submission, patient signature is not mandatory.

☐ **Insurance Information (Section 2)**
Please include a copy of the front and back of the patient's insurance card(s).

☐ **Patient Financial Information (Section 3)**
This section only needs to be completed if you believe the patient could be eligible for the Patient Assistance Program (PAP). For patient assistance consideration, please attach proof of income, ie, wage stubs, employer statement of income, tax returns, etc.

☐ **Physician Information (Section 4)**
Complete with all relevant information and best contact person. Be sure to sign the **Physician Authorization** and **Patient Assistance Program (PAP) Consent For Physician** (if applicable).

☐ **Pharmacy Preference (Section 5)**
Choose your patient's preferred pharmacy (if applicable).

☐ **Prescription Information (Section 6)**
Please complete the selected prescription information for your patient. Ensure that all necessary prescriber signatures are included.

WHAT TO EXPECT NEXT

When sending your Service Request Form to Novartis, please expect a call and/or fax within 24 to 48 hours.

For more information, please call **1-800-282-7630 from 9:00 AM to 8:00 PM EST, Monday through Friday,** or contact your Novartis representative. We look forward to working with you and your patients.

Please see accompanying full Prescribing Information, including **BOXED WARNING** for TASIGNA® (nilotinib) capsules, EXJADE® (deferasirox) tablets for oral suspension, JADENU™ (deferasirox) tablets, FARYDAK® (panobinostat) capsules, VOTRIENT® (pazopanib) tablets, PROMACTA® (eltrombopag) tablets, TYKERB® (lapatinib) tablets, and ARZERRA® (ofatumumab) Injection, for intravenous infusion.

NOVARTIS

NOVARTIS SERVICE REQUEST FORM FOR PATIENT SUPPORT

Please complete the Fax Cover Sheet and Service Request Form, and fax all pages to the number specified on page 1.

1. PATIENT INFORMATION (TO BE COMPLETED BY PATIENT)

Patient's First Name | Last Name | Middle Name

Street Address | **Sex:** ☐ Male ☐ Female

City, State, Zip | Date of Birth

E-mail | Social Security Number

Home Phone | Cell Phone

Contact me by: ☐ Cell Phone ☐ Home Phone ☐ E-mail

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Language Preference

Contact: ☐ Patient ☐ Patient Advocate

Advocate Name | Advocate Phone

Advocate Street Address | Advocate City, State, Zip

PATIENT SIGNATURES

PATIENT AUTHORIZATION – MANDATORY FOR PROCESSING*

*Please note, for ZYKADIA™ (ceritinib) capsules specialty pharmacy processing **only**, patient signature is not mandatory.

I have read and agree to the **Patient Authorization** (section C) on pages 6 and 8 of this document. **(REQUIRED)**

X _____
Patient Signature | Date

PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PATIENT – SIGNATURE NOT REQUIRED FOR PATIENTS NOT APPLYING FOR PAP
I have read and agree to the **Patient Assistance Program (PAP) Consent For Patient** (section D) on page 8 of this document.

X _____
Patient Signature | Date

☐ **Opt-Out Box for Marketing:** Please do not send me marketing information, offers, and promotions from the Novartis Group as described under "Marketing Program" in the Patient Authorization on pages 6 and 8. I understand that I will still be contacted by the Novartis Group in connection with the patient support program as described in the Patient Authorization on pages 6 and 8.

2. INSURANCE INFORMATION

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF THE PATIENT'S INSURANCE CARD(S)

Primary Insurance (PI) Name | PI Subscriber Name

Policy Holder DOB | Policy/Group #

PI Subscriber ID | PI Phone

Prescription insurance (Medicare patients please use Medicare Part D information)

Member ID

Group | Phone

Pharmacy services phone (see back of card)

3. PATIENT FINANCIAL INFORMATION (OPTIONAL)

TO BE COMPLETED BY PRESCRIBER ONLY IF APPLYING FOR PATIENT ASSISTANCE PROGRAM. FOR CONSIDERATION, PLEASE ATTACH PROOF OF INCOME

☐ Patient would like to apply for Patient Assistance Program

US Resident? ☐ Yes ☐ No **Veteran?** ☐ Yes ☐ No **Disabled?** ☐ Yes ☐ No

Total number of adults in household (including patient) | Total number of adults contributing to household income

Salary/Wages $ | Social Security $

Disability $ | Alimony/Child Support $

Unemployment $ | Total Household Gross Monthly Income for previous month

Pension/Retirement $ | Total Household Assets (excluding home and car) $

4. PHYSICIAN INFORMATION

First Name | Last Name

Practice/Institution Name | Specialty

Street Address | City, State, Zip

Office Contact Name | Office Contact Number

Office E-mail | Tax ID #

NPI # | DEA #

Billing information for: ☐ Group ☐ Individual

Tax ID # | NPI #

DEA # | Collaborating Physician Name (if applicable)

5. PHARMACY PREFERENCE (OPTIONAL)

Pharmacy Name

Street Address | City, State, Zip

Phone | Contact Person

PRESCRIBER SIGNATURES

PHYSICIAN AUTHORIZATION – MANDATORY FOR PROCESSING
I have read and agree to the **Physician Authorization** (section A) on page 4 of this document. **(REQUIRED)**

X _____
Prescriber Signature (no stamps) | Date

PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PHYSICIAN – SIGNATURE NOT REQUIRED FOR PATIENTS NOT APPLYING FOR PAP
I have read and agree to the **Patient Assistance Program (PAP) Consent For Physician** (section B) on page 4 of this document.

X _____
Prescriber Signature (no stamps) | Date

Please see accompanying full Prescribing Information, including **BOXED WARNING** for TASIGNA® (nilotinib) capsules, EXJADE® (deferasirox) tablets for oral suspension, JADENU™ (deferasirox) tablets, FARYDAK® (panobinostat) capsules, VOTRIENT® (pazopanib) tablets, PROMACTA® (eltrombopag) tablets, TYKERB® (lapatinib) tablets, and ARZERRA® (ofatumumab) Injection, for intravenous infusion.

NOVARTIS

6. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Patient First Name | Patient Last Name | Patient Date of Birth

Prescriber Name/ Collaborating Physician (if applicable) | DEA # | Tax ID # or NPI #

■ Prescribe AFINITOR® (everolimus) Tablets

Indication: ☐ ABC ☐ RCC ☐ PNET

Rx: AFINITOR® (everolimus) Tablets for oral administration:
Dosage strength (check one)
☐ 2.5 mg ☐ 5 mg ☐ 7.5 mg ☐ 10 mg

Other Dosing _____

Dosing Instructions: Take _____ tablet(s)

Quantity _____ # of days supplied _____

Refills authorized _____ Void after _____ days

Primary Diagnosis/ICD-9/10-CM _____

Secondary Diagnosis/ICD-9/10-CM (if any) _____

Is the requested medication:

☐ New
☐ Continuation of therapy
☐ Reauthorization

☐ **(Optional) Enrolling in AFINITOR 14-Day Free Trial Program**

Patients will receive prompt access to their medication (whether a new prescription or an adjustment to an existing dose*) while insurance coverage is being secured. All patients are eligible for a one-time supply of each dose of AFINITOR for an FDA-approved indication without regard to purchase of AFINITOR or any other product.

*Should a patient require a dosage change, a new 14-day supply can be requested by downloading the 14-Day Free Trial Application form at **www.AFINITOR-now.com**

Dispense 1 AFINITOR tablets box
☐ 2.5 mg ☐ 5 mg ☐ 7.5 mg ☐ 10 mg

To be taken _____

☐ **(Optional) Enrolling in Prior Authorization (PA) Program**

☐ PA process started but have encountered difficulties, causing medically unacceptable time delays
☐ PA process not started but have had significant challenges with oral oncolytics coverage with this payer in the past, causing medically unacceptable delays

(If neither of the above applies, please process the PA independently.)

■ Prescribe VOTRIENT® (pazopanib) tablets

Rx: VOTRIENT® (pazopanib) tablets
Dosage strength 200 mg

Other Dosing _____

Dosing Instructions: Take _____ tablet(s)

Quantity _____ # of days supplied _____

Refills authorized _____ Void after _____ days

Primary Diagnosis/ICD-9/10-CM _____

Secondary Diagnosis/ICD-9/10-CM (if any) _____

■ Prescribe Sandostatin® LAR Depot (octreotide acetate for injectable suspension) ■ Prescribe GLEEVEC® (imatinib mesylate) tablets ■ Prescribe TASIGNA® (nilotinib) capsules

Primary Diagnosis/ICD-9/10-CM _____

Secondary Diagnosis/ICD-9/10-CM _____

Start Date _____ Dosage _____ Refills _____

Name of prior therapies for this diagnosis _____

In combination with (if applicable) _____

For Sandostatin LAR Depot:

Nurse Home Administration:

☐ Yes, I would like a home health nurse to administer Sandostatin® LAR Depot (octreotide acetate for injectable suspension) at the patient's home or other location.
For _____ visits beginning _____

Injection administered at:

☐ Patient's home address (see Patient Information on page 2)

☐ Other (please list street address) _____

! PRESCRIBER SIGNATURES

PRESCRIPTION INFORMATION SIGNATURE – MANDATORY FOR ALL PRODUCTS FOR PRESCRIPTION PROCESSING
I have read and agree to the Prescription Information above. I certify that I am the health care professional who has prescribed the drug above for an FDA-approved indication to the patient identified on this form. I authorize the Novartis Group to transmit prescribing information to a third party(ies) to dispense the drug above to this patient. **(REQUIRED)**

X _____
Prescriber Signature (no stamps) ☐ **Dispense as written** Date

— OR —

X _____
Prescriber Signature (no stamps) ☐ **May substitute** Date

AFINITOR Free Trial Signature – Mandatory For Free Trial Processing
I certify that this therapy is medically necessary, is for an FDA-approved indication, and this information is accurate to the best of my knowledge.
(**OPTIONAL** – Signature not required if patient is not applying to the Free Trial Program)

X _____
Prescriber Signature (no stamps) Date

AFINITOR PRIOR AUTHORIZATION SIGNATURE – MANDATORY FOR PA PROCESSING
I certify that the therapy above is for an FDA-approved indication, is medically necessary, and this information is accurate to the best of my knowledge.
(**OPTIONAL** – Signature not required if patient is not applying to the PA Program)

X _____
Prescriber Signature (no stamps) Date

NOTE: NY prescribers must submit a state-approved prescription with this completed form.

Please see accompanying full Prescribing Information, including **BOXED WARNING** for TASIGNA® (nilotinib) capsules, EXJADE® (deferasirox) tablets for oral suspension, JADENU™ (deferasirox) tablets, FARYDAK® (panobinostat) capsules, VOTRIENT® (pazopanib) tablets, PROMACTA® (eltrombopag) tablets, TYKERB® (lapatinib) tablets, and ARZERRA® (ofatumumab) Injection, for intravenous infusion.

A. PHYSICIAN AUTHORIZATION

My signature on page 2 certifies that I am the physician who has prescribed the selected drug to the patient identified on page 2. I certify that this therapy is medically necessary, and that I have provided the patient with materials that describe the Novartis Service Request Form For Patient Support.

Finally, for the purposes of transmitting this prescription, I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, third-party contractors, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by the patient named on page 2.

B. PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PHYSICIAN
(MANDATORY FOR PATIENTS ENROLLING IN THE PATIENT ASSISTANCE PROGRAM)

My signature on page 2 certifies that the person listed on page 2 is my patient for whom I have prescribed the drug identified on this form. For the purposes of transmitting this prescription, I authorize Novartis Pharmaceuticals Corporation, and its affiliates, business partners, service providers, third-party contractors, and agents, to forward as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to a dispensing pharmacy chosen by the patient named on page 2. I certify that any medications received from Novartis in connection with this application will be used only for the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. I acknowledge that I have assisted the patient in enrolling in the Novartis PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort. I also agree that Novartis has the right to contact the patient directly to confirm receipt of medications, and I understand that Novartis may revise, change, or terminate this program at any time. Finally, to the best of my knowledge, the patient listed on page 2 meets Novartis' eligibility criteria for the PAP.

6. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Patient First Name | Patient Last Name | Patient Date of Birth

Prescriber Name/ Collaborating Physician (if applicable) | DEA # | Tax ID # or NPI #

■ Prescribe TYKERB® (lapatinib) tablets

Rx: TYKERB® (lapatinib) tablets
Dosage strength 250 mg

Other Dosing _____

Dosing Instructions: Take _____ tablet(s)

Quantity _____ # of days supplied _____

Refills authorized _____ Void after _____ days

Primary Diagnosis/ICD-9/10-CM _____

Secondary Diagnosis/ICD-9/10-CM (if any) _____

■ Prescribe ARZERRA® (ofatumumab) Injection, for intravenous infusion

Rx: ARZERRA® (ofatumumab) Injection, for intravenous infusion
Dosage strength (check one)
☐ 1000 mg/50 mL ☐ 100 mg/5 mL

Other Dosing _____

Quantity _____ # of days supplied _____

Refills authorized _____ Void after _____ days

Primary Diagnosis/ICD-9/10-CM _____

Secondary Diagnosis/ICD-9/10-CM (if any) _____

■ Prescribe ZYKADIA™ (ceritinib) capsules

Patient History (optional)
☐ Prior prescription of critzotinib

Prescription Information
Primary Diagnosis/ICD-9/10-CM _____
Secondary Diagnosis/ICD-9/10-CM _____

ZYKADIA™ (ceritinib) 150-mg capsules

Dispense: _____ Refills: _____

Dosing Instructions: Take _____ capsule(s)

☐ **(Optional) Enrolling in ZYKADIA 14-Day Free Trial Program**
This program is available to all patients prescribed ZYKADIA for FDA-approved indications without regard to purchase of ZYKADIA or any other product.

Select your shipping address:
☐ Physician's Address ☐ Patient's Address

ZYKADIA 150-mg capsules
Dispense: 70 Refills: Up to 3 times
Dosing Instructions: Take _____ capsule(s)

■ Prescribe FARYDAK® (panobinostat) capsules

Required:
☐ ICD-9 (203.00) ☐ ICD-9 (203.01) ☐ ICD-9 (203.02)
☐ ICD-10 (C9000) ☐ ICD-10 (C9001) ☐ ICD-10 (C9002)

FARYDAK® (panobinostat) capsules:
10 mg ☐ Dispense ☐ Hold at pharmacy _____ refills
15 mg ☐ Dispense ☐ Hold at pharmacy _____ refills
20 mg ☐ Dispense ☐ Hold at pharmacy _____ refills

Dosing Instructions: _____

To request a FREE FARYDAK 21-Day Trial Prescription
Patients will receive prompt access to their medication while insurance coverage determination is made, or if they encounter coverage issues during their treatment process. This program is available to all patients prescribed FARYDAK for US Food and Drug Administration-approved indications without regard to purchase of FARYDAK or any other product.

Where should we ship the Trial Prescription?
☐ Health Care Provider's Address ☐ Patient's Address

FARYDAK capsules:
☐ 20 mg dispense ☐ 15 mg dispense ☐ 10 mg dispense ☐ Overnight delivery

ZYKADIA or FARYDAK Pharmacy Network – Only the pharmacies in the network can dispense ZYKADIA or FARYDAK. Please fax this form directly to the preferred pharmacy

Accredo Specialty Pharmacy*	Phone: 1-877-732-3431	Fax: 1-888-302-1028
Advanced Care Scripts (ACS)	Phone: 1-877-985-6337	Fax: 1-866-679-7131
Avella Specialty Pharmacy	Phone: 1-877-546-5779	Fax: 1-877-546-5780
Biologics Inc.	Phone: 1-800-850-4306	Fax: 1-800-823-4506
CVS Caremark Specialty Pharmacy*	Phone: 1-800-237-2767	Fax: 1-800-323-2445
Diplomat Specialty Pharmacy	Phone: 1-877-977-9118	Fax: 1-800-550-6272
US Bioservices	Phone: 1-877-757-0667	Fax: 1-888-899-0067
Walgreens Specialty Pharmacy*	Phone: 1-888-782-8443	Fax: 1-866-677-6685

*The ZYKADIA and FARYDAK Free Trial Programs are not accessible through Accredo, Caremark, or Walgreens. Please contact a Novartis representative with any questions.

! PRESCRIBER SIGNATURES

PRESCRIPTION INFORMATION SIGNATURE – MANDATORY FOR ALL PRODUCTS FOR PRESCRIPTION PROCESSING
I have read and agree to the Prescription Information above. I certify that I am the health care professional who has prescribed the drug above for an FDA-approved indication to the patient identified on this form. I authorize the Novartis Group to transmit prescribing information to a third party(ies) to dispense the drug above to this patient. **(REQUIRED)**

X _____
Prescriber Signature (no stamps) ☐ Dispense as written Date

— OR —

X _____
Prescriber Signature (no stamps) ☐ May substitute Date

ZYKADIA OR FARYDAK FREE TRIAL SIGNATURE – MANDATORY FOR FREE TRIAL PROCESSING
I certify that this therapy is medically necessary, is for an FDA-approved indication, and this information is accurate to the best of my knowledge.
(**OPTIONAL** – Signature not required if patient is not applying to the Free Trial Program)

X _____
Prescriber Signature (no stamps) Date

NOTE: NY prescribers must submit a state-approved prescription with this completed form.

Please see accompanying full Prescribing Information, including **BOXED WARNING** for TASIGNA® (nilotinib) capsules, EXJADE® (deferasirox) tablets for oral suspension, JADENU™ (deferasirox) tablets, FARYDAK® (panobinostat) capsules, VOTRIENT® (pazopanib) tablets, PROMACTA® (eltrombopag) tablets, TYKERB® (lapatinib) tablets, and ARZERRA® (ofatumumab) Injection, for intravenous infusion.

C. PATIENT AUTHORIZATION

Please read the following carefully, then sign and date where indicated on page 2.

I give permission for my health care providers (HCP), my pharmacies, my health insurer(s), and third-party contractors or 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, service providers, third-party contractors, 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 the Novartis Oncology medication prescribed by HCP on this Service Request Form, (ii) coordinate my receipt of, and payment for the Novartis Oncology medication prescribed by HCP on this Service Request Form, (iii) facilitate my access to the Novartis Oncology medication prescribed by HCP on this Service Request Form, (iv) provide me with information about the Novartis Oncology medication prescribed by HCP on this Service Request Form, disease awareness and management programs and educational materials, (v) manage the patient 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 patient support program.

I give permission to the Novartis Group to disclose my Personal Information to any pharmacies, my health insurer(s), health care providers, my caregivers, and other third parties for the purposes described above. I give permission to the Novartis Group to contact me directly for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from the 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 patient 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 patient support program may change or end at any time without prior notification. I understand that I have the right to receive a copy of this form.

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. 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. *(continued on page 8)*

6. PRESCRIPTION INFORMATION (TO BE COMPLETED BY PRESCRIBER)

Patient First Name _____ Patient Last Name _____ Patient Date of Birth _____

Prescriber Name/ Collaborating Physician (if applicable) _____ DEA # _____ Tax ID # or NPI # _____

■ Prescribe TAFINLAR® (dabrafenib) capsules

Rx: TAFINLAR® (dabrafenib) capsules
Dosage strength (check one)
☐ 50 mg ☐ 75 mg

Other Dosing _____

Dosing Instructions: Take _____ capsule(s)

Quantity _____ # of days supplied _____

Refills authorized _____ Void after _____ days

Primary Diagnosis/ICD-9/10-CM _____

Secondary Diagnosis/ICD-9/10-CM (if any) _____

■ Prescribe MEKINIST® (trametinib) tablets

Rx: MEKINIST® (trametinib) tablets
Dosage strength (check one)
☐ 0.5 mg ☐ 2 mg

Other Dosing _____

Dosing Instructions: Take _____ tablet(s)

Quantity _____ # of days supplied _____

Refills authorized _____ Void after _____ days

Primary Diagnosis/ICD-9/10-CM _____

Secondary Diagnosis/ICD-9/10-CM (if any) _____

■ Prescribe PROMACTA® (eltrombopag) tablets

Rx: PROMACTA® (eltrombopag) tablets
Dosage strength (check one)
☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ 75 mg ☐ 100 mg

Other Dosing _____

Dosing Instructions: Take _____ tablet(s)

Quantity _____ # of days supplied _____

Refills authorized _____ Void after _____ days

Primary Diagnosis/ICD-9/10-CM _____

Secondary Diagnosis/ICD-9/10-CM (if any) _____

■ Prescribe JADENU™ (deferasirox) tablets ■ Prescribe EXJADE® (deferasirox) tablets for oral suspension

Clinical Information
JADENU™ (deferasirox) tablets and EXJADE® (deferasirox) tablets for oral suspension are contraindicated in patients with:

- Serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance less than 40 mL/min
- Poor performance status
- High-risk myelodysplastic syndromes (MDS)
- Advanced malignancies
- Platelet counts less than 50 x 10^9/L
- Known hypersensitivity to deferasirox or any component of JADENU or EXJADE

☐ Yes, I have read and carefully considered the contraindications listed above for prescribing JADENU or EXJADE for this patient

Prior or current Desferal/deferoxamine patient? ☐ Yes ☐ No

Transfusion history: ☐ <10 units ☐ 10-20 units ☐ >20 units

Transfusions per month _____ Serum ferritin level/Date tested _____

Patient Specialty Pharmacy Preference for EXJADE:
☐ No Preference ☐ Accredo Health Group
☐ Walgreens Specialty Pharmacy ☐ US Bioservices

Prescription Information
# of days supplied: _____ # of refills: _____ Patient weight (kg): _____

Total daily dose for JADENU (must be divisible by 90 mg): _____

Total daily dose for EXJADE (must be divisible by 125 mg): _____

Directions: _____

Other prescribing information: _____

Primary Diagnosis
☐ Sickle Cell Anemia (ICD-9: 282.6)
☐ Thalassemia (ICD-9: 282.49)
☐ Lower-Risk Myelodysplastic Syndromes (ICD-9: 238.75)
(Note: higher-risk MDS is contraindicated)
☐ Other Anemia (please specify): _____

! PRESCRIBER SIGNATURES

PRESCRIPTION INFORMATION SIGNATURE – MANDATORY FOR ALL PRODUCTS FOR PRESCRIPTION PROCESSING
I have read and agree to the Prescription Information above. I certify that I am the health care professional who has prescribed the drug above for an FDA-approved indication to the patient identified on this form. I authorize the Novartis Group to transmit prescribing information to a third party(ies) to dispense the drug above to this patient. **(REQUIRED)**

X _____
Prescriber Signature (no stamps) ☐ **Dispense as written** Date

— OR —

X _____
Prescriber Signature (no stamps) ☐ **May substitute** Date

NOTE: NY prescribers must submit a state-approved prescription with this completed form.

Please see accompanying full Prescribing Information, including **BOXED WARNING** for TASIGNA® (nilotinib) capsules, EXJADE® (deferasirox) tablets for oral suspension, JADENU™ (deferasirox) tablets, FARYDAK® (panobinostat) capsules, VOTRIENT® (pazopanib) tablets, PROMACTA® (eltrombopag) tablets, TYKERB® (lapatinib) tablets, and ARZERRA® (ofatumumab) Injection, for intravenous infusion.

(continued from page 6)

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.

I also consent to receive marketing information, offers, and promotions from the Novartis Group regarding my disease and related conditions and other products and therapies available from the Novartis Group (the "Marketing Program") and to be contacted for my opinions regarding them. I understand that the Personal Information I supply to Novartis Pharmaceuticals Corporation will be shared with and among its business partners to bring me the Marketing Program and/or to conduct market research. I may opt-out of the Marketing Program by separately checking the Opt-Out Box on page 2, or 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.

D. PATIENT ASSISTANCE PROGRAM (PAP) CONSENT FOR PATIENT
(MANDATORY FOR PATIENTS ENROLLING IN THE PATIENT ASSISTANCE PROGRAM)

I give permission for my doctor(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition, and health ("Health Information") to the Novartis Patient Assistance Foundation, Inc. (the "Foundation") so that the Foundation can decide if I am eligible for the Novartis Patient Assistance Program ("PAP"); operate the PAP and the Foundation; send me information about PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; ask me for financial, insurance, and/or medical information and share my information as required or permitted by law. I give permission to the Foundation to use information on this Application and any other information I give to the Foundation for these same reasons. I also give the Foundation permission to share my Health Information and other information with people and companies that work with the Foundation; government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my doctor(s) and other people or institutions who are involved in my health care, such as pharmacies and hospitals; other organizations that might help me pay for my medication. I promise that any information, including financial and insurance information that I provide to the Foundation, are complete and true and unless I have said something different in this application, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call the PAP at 1-800-277-2254. I know that the Foundation may change or end the PAP at any time. I know that if I do not sign this form, I will not be able to participate in the PAP, but this will not affect my ability to get medical care, seek payment for this care, or affect my enrollment or eligibility for insurance. I know that I can cancel this permission at any time by calling the PAP at 1-800-277-2254. If I do, then I will not be able to stay in the PAP. I understand that I have the right to receive a copy of this form.

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7/15 ONC-1112163