

**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 \_\_\_\_\_  
 Patient Primary Phone \_\_\_\_\_  Mobile  Landline  
 Patient Alternate Phone \_\_\_\_\_  Mobile  Landline

Patient Email (required for co-pay enrollment) \_\_\_\_\_  
 OK to leave message about COSENTYX® on:  Cell Phone  Home Phone  Authorized Alt. Contact  
 Preferred Language:  English  Spanish  Other \_\_\_\_\_  
 Authorized Alternate Contact Name \_\_\_\_\_  
 Authorized Alternate Contact Phone \_\_\_\_\_  Mobile  Landline  
 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 3.

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.

**I have read and agree to the Patient Authorization on page 2.**

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.

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

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 auto dialed or prerecorded and are not a condition of purchase.

**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)**

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

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

**4. CLINICAL INFORMATION**

**PRIMARY DIAGNOSIS/ICD-10-CM Codes: (check one)**  
 L40.00: (Plaque psoriasis)  M45.0: (Ankylosing spondylitis)  
 L40.50: (Arthropathic psoriasis, unspecified)  M46.80: (Non-radiographic axial spondyloarthritis)  
 L40.59: (Other psoriatic arthropathy)  Other ICD-10-CM Code(s): \_\_\_\_\_

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

**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

**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

**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.**

**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

**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)? \_\_\_\_\_

**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)? \_\_\_\_\_

FIRST DOSE SHIPPING:  Prescriber Address  Patient Address

**ALL SUBSEQUENT DOSES WILL BE SHIPPED TO THE PATIENT**

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.

**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.

**PRESCRIBER SIGNATURE & DATE**  
 \_\_\_\_\_ Date \_\_\_\_\_  
**CANNOT PROCESS RX WITHOUT THIS COMPLETED** (No Stamp Allowed) (MM/DD/YYYY)

**PRESCRIBER SIGNATURE & DATE**  
 \_\_\_\_\_ Date \_\_\_\_\_  
**CANNOT PROCESS RX WITHOUT THIS COMPLETED** (No Stamp Allowed) (MM/DD/YYYY)



**2020 UPDATE**

**SERVICE REQUEST FORM (SRF), PRESCRIPTIONS,  
AND COSENTYX® CONNECT PATIENT SUPPORT ENROLLMENT FORM  
PHONE: 1-844-267-3689; FAX: 1-844-666-1366**

*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.



## 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.

**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) Jane A. Doe  
 DOB (MM/DD/YYYY) 09/27/1963 Sex:  M  F  
 Street Address 1246 Hanson Way  
 City Raleigh State NC Zip Code 23645  
 Patient Primary Phone 919-123-5555  Mobile  Landline  
 Patient Alternate Phone 919-123-4567  Mobile  Landline

Patient Email (required for co-pay enrollment) JDoe@yahoo.com  
 OK to leave message about COSENTYX® on:  Cell Phone  Home Phone  Authorized Alt. Contact  
 Preferred Language:  English  Spanish  Other  
 Authorized Alternate Contact Name Jan B. Sample  
 Authorized Alternate Contact Phone 919-321-5555  Mobile  Landline  
 Relationship to Patient Parent

**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.

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.

**I have read and agree to the Patient Authorization on page 2.**  
 Date 01/15/2020  
**CANNOT PROCESS FORM WITHOUT THIS COMPLETED** Legal signature (MM/DD/YYYY)

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 auto-dialed or prerecorded and are not a condition of purchase.

**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)**

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 Code 27529

**4. CLINICAL INFORMATION**

**PRIMARY DIAGNOSIS/ICD-10-CM Codes:** (check one)  
 L40.00: (Plaque psoriasis)  M45.0: (Ankylosing spondylitis)  
 L40.50: (Arthropathic psoriasis, unspecified)  M46.80: (Non-radiographic axial spondyloarthritis)  
 L40.59: (Other psoriatic arthropathy)  Other ICD-10-CM Code(s): \_\_\_\_\_

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

**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

**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

**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.**

**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

**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)?** 3

**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)?** 3

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

**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.

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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.

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

 Date 01/15/2020  
**CANNOT PROCESS RX WITHOUT THIS COMPLETED** (No Stamp Allowed) (MM/DD/YYYY)

 Date 01/15/2020  
**CANNOT PROCESS RX WITHOUT THIS COMPLETED** (No Stamp Allowed) (MM/DD/YYYY)