Novartis Patient Support™

FABHALTA® (iptacopan) START FORM

*** = REQUIRED FIELDS**

Please fill out all fields on this form to enroll in Novartis Patient Support.

☐ **Vaccination Support† Only:** Check this box and complete all required fields below if you would like to enroll in vaccination support ***only*** for your patient (and no other services).

1. Patient Information

First Name* | Last Name*

Email

Date of Birth (MM/DD/YYYY)* | Sex for Clinical Use*: ☐ Male ☐ Female

Phone Number*‡ ☐ Mobile ☐ Home — *We'll keep you updated through non-marketing calls and texts.*

Address (No PO Box)*

OK to Leave Voicemail: ☐ Yes ☐ No

City | State | ZIP

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

I give permission to disclose my personal health information to the following Caregiver (optional):

Caregiver Name | Relationship to Patient

Caregiver Phone Number — *We'll keep you updated through non-marketing calls and texts.*

2. Patient Authorization and Additional Enrollment Consents

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

X _____ / / _____

Patient/Authorized Representative Signature* | **Date (MM/DD/YYYY)***

☐ Check here if signed by an Authorized Representative.

CO-PAY PLUS§

☐ I have read and agree to the Co-Pay Plus Terms and Conditions on page 3.

ONGOING SUPPORT FROM NOVARTIS PATIENT SUPPORT

You can also get continued one-on-one support from your dedicated Novartis Patient Support Team by checking the box below.

☐ I agree to receive marketing calls and texts from and on behalf of Novartis and its affiliates, including calls and texts made with an autodialer or prerecorded voice, at the phone number(s) I provide. I understand that my consent is not required and is not a condition of receiving any goods or services from Novartis.

3. Insurance Information

To prevent delays, please include copies (front and back) of the patient's prescription insurance card(s). Include primary and secondary prescription insurance.

Check all that apply*: ☐ Primary ☐ Secondary ☐ Prescription ☐ Patient Is Uninsured

4. Prescriber Information

First Name* | Last Name*

Practice Name

Address

Practice Phone Number

City | State | ZIP*

Office Contact Name | Office Contact Phone

Prescriber NPI Number*

Office Fax*

Tax ID Number | State License Number

Office Email

Send Fax
1-877-44FABHA (1-877-443-2242)

Questions? Call
1-833-99FABHA (1-833-993-2242)

Complete entire form and fax to Novartis Patient Support at 1-877-44FABHA (1-877-443-2242).

An incomplete Start Form may delay the start of treatment.

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5. Vaccination Information

Patient Name* _____ Date of Birth (MM/DD/YYYY)* ____/____/____

FABHALTA is available through a Risk Evaluation and Mitigation Strategy (REMS) program. Additional information is available by telephone at 1-866-201-3101 or online at www.FABHALTA-REMS.com.

Please select one of the options below and sign the prescriber attestation*:

Vaccinate patients against encapsulated bacteria, including *Streptococcus pneumoniae*, *Neisseria meningitidis* (serogroups A, C, W, Y and B), and *Haemophilus influenzae* type B, according to current ACIP recommendations at least 2 weeks prior to initiation of FABHALTA.

☐ **SHIP AS SOON AS POSSIBLE—NO PRESCRIBER HOLD**
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history and certify that vaccinations will be completed OR antibiotic prophylaxis will be prescribed and will be continued until vaccinations have been completed. FABHALTA is authorized to be dispensed as soon as possible.

OR

☐ **HOLD SHIPMENT—CONTACT OFFICE PRIOR TO DISPENSE**
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history, and I request that the FABHALTA shipment be held with additional follow-up provided to my office as necessary.

Please provide relevant vaccination and antibiotic prophylaxis information for your patient below to support REMS requirements for FABHALTA:

Current ACIP recommendations available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html

Please mark the checkbox below if your patient will need vaccination support to help comply with REMS requirements. A dedicated Novartis Team Member will follow up with your patient and provide more information.

☐ My patient requires vaccination support from Novartis Patient Support.

▶ Antibiotic prophylaxis administered? ☐ Yes ☐ No If yes, start date: ____/____/____ (MM/DD/YYYY)

▶ Vaccines administered? Document the appropriate vaccine type, brand administered, and the administration date (using the MM/DD/YYYY format) of the most recent dose.

MenACWY
1st Dose Date: ____/____/____
☐ Menveo ☐ Menactra ☐ MenQuadfi
2nd Dose Date: ____/____/____
☐ Menveo ☐ Menactra ☐ MenQuadfi

MenB
1st Dose Date: ____/____/____
☐ Bexsero ☐ Trumenba
2nd Dose Date: ____/____/____
☐ Bexsero ☐ Trumenba
3rd Dose Date: ____/____/____
Only applicable to Trumenba

Pneumococcal
1st Dose Date: ____/____/____
☐ PCV13 ☐ PCV15 ☐ PCV20 ☐ PPSV23
2nd Dose Date: ____/____/____
☐ PCV15 ☐ PCV20 ☐ PPSV23
If applicable

HIB
1st Dose Date: ____/____/____
☐ ActHIB ☐ Hiberix

6. Prescription Information

Preferred Specialty Pharmacy: ☐ Onco360 ☐ Biologics ☐ Other: _____

Primary Diagnosis Code*: ☐ D59.5 Paroxysmal nocturnal hemoglobinuria ☐ Other: _____

Pharmacy Prescription:

Product Information	Dosage and Administration	Quantity (60 or 180 capsules)	Refills
FABHALTA 200 mg capsule	200 mg orally twice daily	_____ capsules	☐ 11 refills, or _____ refills

Prescriber Attestation*

Prescriber must authorize these instructions by signing at the end of this section.

I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the prescriber who has prescribed FABHALTA to the patient named on this form. I certify that any medication received from Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") or the Novartis Patient Assistance Foundation, Inc., and its service providers ("NPAF"), will be used only for the patient named on this form and will not be offered for sale, trade, or barter, returned for credit, or submitted for reimbursement in any form. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Novartis and NPAF may revise, change, or terminate their respective programs at any time. I authorize Novartis and NPAF to forward, as my agent, these prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. **I have discussed the Novartis Patient Support Program with my patient, who has authorized me under HIPAA and state law to disclose their information to Novartis for the limited purpose of enrolling in Novartis Patient Support. To complete this enrollment, Novartis may contact the patient by phone, text, and email.**

→ X _____ _____ _____ ____/____/____

Prescriber Signature (Dispense as Written) **(Substitution Permissible)** **Prescriber Name (Print Name)*** **Date (MM/DD/YYYY)***

ATTN: Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).

Send Fax
1-877-44FABHA (1-877-443-2242)

Questions? Call
1-833-99FABHA (1-833-993-2242)

Complete entire form and fax to Novartis Patient Support at 1-877-44FABHA (1-877-443-2242).

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Novartis
Patient Support

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 copay 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 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 I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling 1-833-99FABHA (1-833-993-2242) or by writing to:

Novartis Patient Support
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 Provider's 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.

Novartis Patient Support Terms and Conditions

†**Vaccination Support**: Limitations apply. Please contact Novartis Patient Support at 1-833-99FABHA (1-833-993-2242) for more information.

§**Co-Pay Plus:** Limitations apply. Patients with commercial insurance coverage for FABHALTA may receive up to $20,000 in annual co-pay benefits for the cost of FABHALTA and up to $1,000 for qualifying vaccination costs (excluding administrative fees). 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 health care 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. 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 health care 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 United States, Puerto Rico and select territories. Void where prohibited by law. Additional restrictions may apply. 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.

Bridge Program: Limitations apply. Patients with commercial insurance, a valid prescription for FABHALTA, and a denial of insurance coverage based on a prior authorization requirement may receive a monthly dose for up to 12 months or until insurance coverage approval, whichever occurs first. Not available to patients whose medications are reimbursed in whole or in part by Medicare, Medicaid, TRICARE, VA, DoD or any other federal or state program, or where prohibited by law. A prior authorization and/or appeal of coverage denial must be submitted within 90 days to remain in the program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Additional restrictions may apply. Novartis reserves the right to rescind, revoke or amend this Program without notice.

‡Novartis Patient Support may call and text you at the numbers provided for non-marketing purposes (e.g., to help you access and start on FABHALTA). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 1-833-99FABHA (1-833-993-2242).

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

Please see the Novartis Pharmaceuticals Corporation Privacy Policy at http://www.novartis.com/us-en/privacy.

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FABHALTA (iptacopan) 200 mg capsules