



Dear Health Care Professional,

The Patient Assistance Now Oncology (PANO) Service Request Form helps assess patient eligibility for all Novartis Oncology 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.

Enroll now to submit your reimbursement service request forms electronically.
Go to oncologyaccessnow.com and click on Provider Portal for more information.

PLEASE NOTE: IF YOU DO NOT BELIEVE THE PATIENT IS ELIGIBLE FOR THE PATIENT ASSISTANCE PROGRAM, STEP 4 DOES NOT NEED TO BE COMPLETED.

Both the health care professional and the patient will be contacted with information if a patient is deemed eligible for any program.

PANO Support For Patients Includes:

- Insurance verification
- Medicare education
- Assistance with denials/appeals
- Therapy-specific support programs for out-of-pocket costs
- Assistance searching for other sources of coverage/funding that could alleviate or reduce costs for patients
- Referrals to independent charitable foundations for assistance with co-pay costs
- Patient assistance for low-income and uninsured patients
- Patients prequalified via phone screening for the Patient Assistance Program (PAP) will be sent a 30-day supply of their needed medication while completing the application

FOLLOW THE STEPS BELOW TO COMPLETE THE SERVICE REQUEST FORM

STEP 1	Complete Patient Information Please include a copy of the front and back of the patient's insurance card(s). ICD-9 code information for the patient is mandatory. Without this information, services may be delayed.
STEP 2	Prescriber Information Complete Prescriber Information with all relevant information, best contact person, and time to call.
STEP 3	Preferred Pharmacy Information If your patient has a preferred pharmacy that they would like to utilize for drug fulfillment, please have them complete this section.
STEP 4	Patient Assistance Program This section only needs to be completed if you believe the patient could be eligible for the PAP. In the event that the patient does meet eligibility guidelines, your office will be contacted with a request to submit a prescription.
STEPS 5 6	Authorization Sections Please have the physician sign the physician authorization section. Please have the patient sign the patient authorization section.

AFTER COMPLETING THE STEPS ABOVE, PLEASE FAX THE FORM TO 1-888-891-4924

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

Please select product(s): Afinitor® (everolimus) Gleevec® (imatinib mesylate) Tasciga® (nilotinib)
 Sandostatin® LAR (octreotide acetate for injectable suspension) Zometa® (zoledronic acid)

STEP 1 | Complete Patient and Insurance Information

(Please include copies of the front and back of your patient's insurance cards)

First name _____ Last name _____

Address _____

City _____ State _____ ZIP _____

Home phone _____ Best time to call _____ AM/PM _____

Cell phone _____ Email address _____

Language preference _____ Sex M F Date of Birth: _____ (MM/DD/YYYY)

Social Security # _____

Do you have prescription drug coverage? Y N

Are you enrolled in Medicare Part D? Y N

Primary diagnosis ICD-9-CM code: _____ Secondary diagnosis (if any) ICD-9-CM code: _____

Primary insurance name _____

Beneficiary/Cardholder name _____ ID # _____

Group # _____ Phone _____

Secondary insurance _____

Beneficiary/Cardholder name _____ ID # _____

Group # _____ Phone _____

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

Group # _____ Phone _____

Pharmacy services phone (see back of card) _____

New to therapy? Y N

Current therapy (if applicable) _____

STEP 2 | Complete Prescriber Information

First name _____ Last name _____ Suffix _____

Site name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Email address _____

Specialty _____ DEA # _____

Tax ID # _____

NPI # _____

Office contact _____ Office contact phone _____

STEP 3 | Preferred Pharmacy Information

Name of pharmacy _____

Phone _____ Fax _____

Address _____

City _____ State _____ ZIP _____

STEP 4 | Complete Patient Financial Information

This step is not required if you are not applying for the patient assistance program. (FOR PATIENT ASSISTANCE CONSIDERATION, PLEASE ATTACH PROOF OF INCOME)

Total number in household (including patient) _____

Number of adults contributing to household income _____

Are you a US resident? Y N

Are you a veteran of the US Armed Forces? Y N

Have you received disability payments from Social Security for more than 24 months? Y N

Do you have an application pending with Medicaid? Y N

Salary/Wages \$ _____ Social Security \$ _____

Disability \$ _____ Pension/Retirement \$ _____

Alimony/Child support \$ _____ Unemployment/Workman's comp \$ _____

Total household gross monthly income \$ _____

Total household assets (exclude first home and car) \$ _____

STEP 5 | Read & Sign Physician Authorization

I have read and agree to the Physician Authorization **Section A** on page 2 of this document. *(Signature required)*

X _____ (MM/DD/YYYY)
 Prescriber signature

I have read and agree to the Physician Consent for the Patient Assistance Program **Section B** on page 2 of this document. *(Signature not required if patient not applying to the Patient Assistance Program)*

X _____ (MM/DD/YYYY)
 Prescriber signature

STEP 6 | Read & Sign Patient Authorization

I have read and agree to the Patient Authorization **Section C** on page 2 of this document. *(Signature required)*

X _____ (MM/DD/YYYY)
 Patient/Legal guardian signature

I have read and agree to the Patient Authorization **Section 2C** on pages 2 and 3 of this document. *(Signature required)*

X _____ (MM/DD/YYYY)
 Patient/Legal guardian signature

I have read and agree to the Patient Assistance Program Consent **Section D** on page 3 of this document. *(Signature not required for patients not applying to the Patient Assistance Program)*

X _____ (MM/DD/YYYY)
 Patient/Legal guardian signature

A → Physician Authorization

I authorize Novartis Pharmaceuticals Corporation, its affiliates, business partners and agents (together, the “Novartis Group”) to use and disclose the patient’s health information and information relating to the patient’s insurance coverage so that the Novartis Group can (i) verify the patient’s insurance coverage or coordinate insurance coverage or otherwise obtain payment for the patient’s treatment with a Novartis Oncology product indicated on page 1, and (ii) provide information about the patient’s insurance coverage to other health care providers who are involved in the patient’s treatment with a Novartis Oncology product indicated on page 1. I certify that I have on file an authorization from my patient that permits me to disclose (and authorize the further disclosure of) the patient’s health and insurance information for these purposes. I certify that I have provided the patient with materials that describe Novartis Patient Assistance NOW Oncology (“Program”) and have enrolled the patient in this program at the patient’s request and that the patient agrees to be contacted by Program administrators.

B → Patient Assistance Program Consent For Physician *(to be signed only if patient is applying to PAP)*

My signature above certifies that the person listed is my patient for whom I have prescribed the drug identified above. I certify that any medications received from Novartis Group (as defined above) 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 above meets Novartis’ eligibility criteria for the PAP.

C → Patient Authorization

I authorize my doctor(s) and their staff, my employer, and my health insurer(s) 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, 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 a Novartis Oncology product, (ii) coordinate my receipt of, and payment for, a Novartis Oncology product indicated on page 1, and Patient Assistance NOW Oncology (“Program”), and (iii) conduct market research, quality assurance, and other internal business activities.

2C → I authorize the Novartis Group to disclose my Personal Information to any pharmacies, insurance carriers, health care providers (including my doctor(s) and their staff) and other third parties for the purposes described above. I understand that these other parties may report back to the Novartis Group any Personal Information about me that they may create or receive and that Novartis Group may disclose such Personal Information to my doctor(s) and their staff. I authorize the Novartis Group to contact me directly for the purposes described above. I agree

to receive phone calls and materials from the Novartis Group at the number and address listed on page 1 of this form. I understand that once my health information is disclosed it may no longer be protected by federal or state law regarding patient privacy and that neither my doctor(s), my employer, nor my health insurer can guarantee that it will not be re-disclosed to a third party. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect the commencement, continuation, or quality of my treatment by my doctor(s). However, I understand that if I revoke this authorization, I may no longer be eligible to participate in the Program. I understand that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier by calling 1-800-282-7630. I also understand that the Program may be changed or terminated at any time without prior notification. I understand that I may receive a copy of this authorization.

D → Patient Assistance Program Consent For Patient *(to be signed only if applying to PAP)*

I authorize the Novartis Patient Assistance Foundation, Inc. (“Foundation”) and its affiliates and agents (collectively “Novartis”) to use and/or disclose among Novartis the information on this Service Request Form and any other information I provide to Novartis in relation to the Novartis Oncology Patient Assistance Program (“My Information”) to determine if I am eligible to participate in the Novartis Oncology Patient Assistance Program (“PAP”) and for the operation and administration of the PAP and other Foundation programs. I further authorize Novartis to disclose My Information to governmental agencies, including the Centers for Medicare and Medicaid Services, and to insurance plans, including Medicare Part D plans (“Government”) and that they may disclose My Information to and among themselves and Novartis in furtherance of the activities and administration of the PAP. By signing above, I verify that the information on this application, including the signed copy of my prior year’s tax return and other supporting documentation, is complete and accurate. I also verify that unless I have identified otherwise in this application, I have no other coverage for prescription medications, including Medicaid, Medicare or any public or private assistance programs or any other form of insurance. I also agree that Novartis may verify my eligibility for the PAP, and understand that such verification may include contacting me or my health care provider for additional information and/or reviewing additional financial, insurance, and/or medical information. In connection with administering the PAP, I understand that Novartis may contact me or my health care provider directly to confirm receipt of medications or to provide other information related to the PAP. I also understand that Novartis may revise, change, or terminate the PAP at any time. I understand that if I refuse to sign this authorization, I will not be able to participate in the PAP, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance coverage. Further, I understand that I can cancel this authorization at any time by contacting the Novartis PAP, but if I do so I will no longer be eligible to participate in the PAP.