PATIENT | PANO Service Request Form

For more information, please call 1-800-282-7630 from 8:00 AM to 8:00 PM ET, Monday through Friday.

Complete the patient PANO (Patient Assistance Now Oncology) Service Request Form to find out if you qualify for Novartis Oncology programs that may provide financial support and free trial offers. Your information will be processed in tandem with the information your physician submits on your behalf to finalize the request. It is essential to complete the form in full, including all required fields and authorizations. To complete this form, you must be 18 years of age or older.

Fax Number: 1-888-891-4924

***Required Fields**

Patient Information

First Name*	Last Name*	Date of Birth*	Gender*: ☐ Male ☐ Female
Street Address*	City*	State*	Zip Code*
Email	Home Phone Number*	Cell Phone Number	
OK to leave detailed voice mail about your medication on your phone* ☐ Yes ☐ No	Designated Contact* ☐ Patient ☐ Patient Caregiver/Advocate ☐ Parent/Legal Guardian		
Caregiver/Advocate Name	Caregiver/Advocate Phone		
Parent/Legal Guardian Name	Parent/Legal Guardian Phone		
Physician First Name*	Physician Last Name*	Office Contact Number*	Office Contact Fax

Insurance

Insurance Name	Member ID	Rx Group #	Rx Bin #	Customer Service Phone (See back of card)

Novartis Patient Assistance Foundation, Inc. (NPAF)

The Novartis Patient Assistance Foundation, Inc. (NPAF) is committed to providing access to Novartis medications for those most in need. If you are experiencing financial hardship, cannot afford the cost of your treatment, and have limited or no prescription coverage, then you may be eligible to receive Novartis medications for free.†

†Please be advised that access to the medicines distributed through the Novartis Patient Assistance Foundation, Inc., is free of charge to all eligible patients. Novartis is not affiliated with any individual or organization that may charge patients a fee(s) to assist them in completing applications for our program. These individuals or organizations are acting independently of the Novartis Patient Assistance Foundation, Inc., and its affiliates and do not have the consent of Novartis.

To be eligible, a patient must:

- Reside in the United States or a U.S. Territory
- Have limited or no prescription insurance coverage
- Meet income guidelines adjusted for household size, for the medication for which the patient is seeking assistance. Visit www.pap.novartis.com.
- Have a valid prescription for the Novartis medication
- Be treated by a licensed U.S. healthcare provider on an outpatient basis

Eligibility into the NPAF program requires that you provide your proof of income. You must send in a copy of the first 2 pages of your latest Federal tax return (e.g., 1040).

US Resident: ☐ Yes ☐ No

Total number of people in the home (including self):

Please fax the documentation to 1-888-891-4924.

Patient Authorization – Required for Processing

☐ I confirm that the information provided herein is truthful and accurate to the best of my knowledge.

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

☐ I have read and agree to the Patient Authorization on page 2 on this document. If I am eligible, I would like to be considered for the Novartis Patient Assistance Foundation, Inc., which may provide my medication for free.

X _____ _____

Patient/Legal Guardian Signature* Date

PATIENT AUTHORIZATION

I authorize my health care 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. ("NPAF"), and its service providers 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.
- Contact me by phone, email, and/or text regarding the above services and/or available programs that provide general education, support, disease education, and logistical support.

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 health care providers may receive payment from Novartis or NPAF for providing certain 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 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 1-800-282-7630 or writing to

McKesson
PO Box 1330
Columbus, OH 43216

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 non-marketing calls and texts from Novartis or NPAF, including through an autodialer or prerecorded voice, at the number(s) provided.

TELEPHONE CONSUMER PROTECTION ACT (TCPA) CONSENT (OPTIONAL)

I consent to receive marketing calls and texts from and on behalf of Novartis Pharmaceuticals Corporation, made with an autodialer 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.

TERMS AND CONDITIONS FOR TCPA-RELATED ACTIVITIES

By signing up to receive marketing texts and calls, or by requesting information by telephone, text message, fax, email, direct mail, or other means, you accept, without limitation or qualification, that:

- You and Novartis agree that any legal disputes or claims arising out of or related to the Terms and Conditions, or the use of the Novartis products and/or the Services (including but not limited to telephone calls or text messages sent by Novartis), or the interpretation, enforceability, revocability, or validity of the Terms and Conditions, or the arbitrability of any dispute), that cannot be resolved informally shall be submitted to binding arbitration in the state in which the Terms and Conditions was performed. The arbitration shall be conducted by the American Arbitration Association under its Commercial Arbitration Rules.
- This arbitration clause is an independent agreement and shall survive the termination and/or transfer of these Terms and Conditions or any other agreement between you and Novartis. If any provision of the agreement to arbitrate in this Section is found unenforceable, the unenforceable provision will be severed and the remaining arbitration terms will be enforced (but in no case will there be a class, representative, or private attorney general arbitration). Any judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Claims shall be brought within the time required by applicable law. The laws of the State of New York will govern the Terms and Conditions and the Federal Arbitration Act, 9 U.S.C. §§ 1-16, will govern this Section, without giving effect to any principles of conflicts of laws. Each party shall bear its own costs relating to the arbitration consistent with the Commercial Arbitration Rules of the American Arbitration Association.
- You and Novartis agree that any claim, action, or proceeding arising out of or related to the Terms and Conditions or telephone calls or text messages sent by Novartis

must be brought in your individual capacity, and not as a plaintiff or class member in any purported class, collective, or representative proceeding. The arbitrator may not consolidate more than one person's claims, and the arbitrator may not otherwise preside over any form of a representative, collective, or class proceeding.

YOU ACKNOWLEDGE AND AGREE THAT YOU AND NOVARTIS ARE EACH WAIVING THE RIGHT TO A TRIAL BY JURY OR TO PARTICIPATE AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS ACTION OR REPRESENTATIVE PROCEEDING.

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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