INSTRUCTIONS FOR ENROLLMENT

Sandoz Patient Assistance (SPA) Enrollment Form

SANDOZ A Novartis Division

Please visit us.sandoz.com/pap for a complete list of medications and income requirements to see if you are eligible.

ELIGIBILITY CHECKLIST

- ☐ Reside in the United States or a U.S. Territory
- ☐ Have limited or no prescription insurance coverage
- ☐ Meet income guidelines for the medication for which the patient is seeking assistance (visit us.sandoz.com/pap)
- ☐ Have a valid prescription for the Sandoz medication
- ☐ Be treated by a licensed U.S. health care provider

SUPPORTING DOCUMENTS

- ☐ Insurance Information: Copies of the front and back of all insurance card(s) (e.g., medical, pharmacy, etc., if you did not complete section 2 on page 2)
- ☐ Prior Authorization (PA): Include all PA and appeal results with the Prescriber's application submission. Prescriber must manage any PA that is required by insurance companies.
- ☐ Benefits Investigation (BI): Include all BI results with the Prescriber's application (if available).

Patient Instructions

- ☐ Check us.sandoz.com/pap to see if you may be eligible for the program.
- ☐ Check your application and make sure all fields are filled in or marked N/A.
- ☐ Read the Patient Authorization and the Terms & Conditions on pages 3 and 4.
- ☐ Sign and date the Patient application on page 4.

Prescriber Instructions

- ☐ Fax in the completed Prescriber Application page and all supporting documentation.
- ☐ Prescriber must fax separate prescription along with the Prescriber's application.
- ☐ Include Benefits Investigation results for the patient (if available).
- ☐ Manage any Prior Authorization (PA) that is required by insurance companies.
  - Include all PA and Appeal results with the Prescriber's application submission.
- ☐ Read the attestation, sign and date the form on page 5.

Applications MUST be filled out completely and accurately.
Any missing information will result in a processing delay or application denial.

Fax or mail the completed form and supporting documents to:
Fax: 1-855-530-1382 -OR- Mail: Sandoz Patient Assistance, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560

For assistance on how to complete the form or questions about the program, call **1-833-4SANDOZ (1-833-472-6369)**, Monday through Friday, 8:00 AM - 5:00 PM MT.

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TO BE COMPLETED BY PATIENT: All information is required.

☐ I am a new patient ☐ I am re-enrolling

1. Patient Information

First Name: _____ **Last Name**: _____

Date of Birth (*mm/dd/yyyy*): _____ **Gender**: _____

Reside in U.S. or Territory: ☐ **Yes** ☐ **No** **Email**: _____

Address Line 1: _____ **Address Line 2**: _____

City: _____ **State**: _____ **ZIP Code**: _____

Mobile #: _____ **Home #**: _____

Employer Name: _____

If patient is a minor, please provide the information below:

Parent/Guardian First Name: _____ **Last Name**: _____

Phone #: _____ **Relationship**: _____

Insurance Information *(Complete for ALL available insurance OR submit copies of front and back of ALL insurance cards)*

☐ I have no prescription drug coverage.

Primary Prescription Insurance: _____ Plan Name: _____

Policy #: _____ Phone: _____

Primary Medical Insurance: _____ Plan Name: _____

Policy #: _____ Phone: _____

3. Financial Information

Total Gross Annual Income

Entire household: $ _____

Household Size

Including yourself, the number of people who live in your home and are dependent on your household income: _____

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Patient Authorization Form

SANDOZ A Novartis Division

Patients should read the Patient Authorization, check the desired permission boxes, and return both pages of the form to Sandoz Patient Assistance.

The completed form may be faxed to 1-855-530-1382 or mailed to Sandoz Patient Assistance, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.

I give permission for my health care providers (HCPs), pharmacies, health insurer(s), third party contractors, and service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Sandoz, its affiliates, business partners, and agents (together "Sandoz") so that Sandoz can (i) help verify or coordinate insurance coverage or otherwise obtain payment for my treatment with a Sandoz product, (ii) coordinate my receipt of and payment for my prescribed Sandoz product, (iii) provide or facilitate my access to my prescribed Sandoz product, (iv) provide me with information about a Sandoz product, disease awareness, management programs, and educational materials, (v) manage the Sandoz Patient Assistance Program, (vi) provide me with adherence reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with Sandoz Patient Assistance (SPA), and (viii) to send me information about programs that might help me pay for my medicines, and to coordinate and share my Personal Information with my health care providers, other programs that might help me pay for medicines, government agencies, and insurance companies for purposes of providing or facilitating this assistance.

I give permission to Sandoz to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from Sandoz in exchange for disclosing my personal information to Sandoz 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 and state privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization with respect to SPA at any time in the future by calling 1-833-472-6369.

My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctors; however, if I revoke this authorization, I may no longer be able to participate in SPA and/or programs administered by Sandoz. If I revoke this authorization, Sandoz 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 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 SPA and/or programs administered by Sandoz may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

I agree to be contacted by Sandoz by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on SPA patient enrollment form for all purposes described in this Patient Authorization. I also agree to be contacted by Sandoz, and others on its behalf by telephone calls and text messages made by or using an automatic telephone dialing system or prerecorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys. 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 Sandoz promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that Sandoz 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.

Telephone Consumer Protection Act (TCPA) Consent: I consent to receive marketing and non-marketing calls and texts from and on behalf of Sandoz, made with an auto dialer 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; average of 1-2 messages per week. Message and data rates may apply. Privacy Policy at us.sandoz.com/privacy-policy. Text STOP to opt out and HELP for help.

Fair Credit Reporting Act (FCRA) Authorization: I understand that I am providing "written instructions" authorizing SPA and its vendor, under the FCRA, to obtain information from my credit profile or other information from Experian Health, solely for the purpose of determining financial qualifications for programs administered by SPA. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide are complete and true and, unless I have indicated otherwise, 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 SPA at 1-833-472-6369. If eligible, I would like to be considered for programs administered by Sandoz.

Terms & Conditions

SANDOZ A Novartis Division

Sandoz Patient Assistance (SPA) Terms & Conditions: SPA provides free medicine to qualifying patients. Participation in our program is free. Medication assistance is dependent on your ability to meet the eligibility criteria for our program as determined by SPA. SPA does not have any obligation to provide the program services to you and is not liable in the provision of these services. Patients with insurance plans or employers that require them to apply to a manufacturer's patient assistance program as a condition of, requirement for, or prerequisite to coverage of relevant Sandoz products, or that insurance plans or employers that deny, restrict, eliminate, delay, or withhold any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through SPA are not eligible for the SPA program. You agree to inform SPA if you are a member of such an insurance plan or if you are applying to SPA on behalf of a patient who is a member of such an insurance plan. The program may be changed or discontinued without notice. You will not seek reimbursement for any products dispensed under the program. You must notify the program if your insurance or financial situation changes. If you are a member of a Medicare plan including a Medicare Prescription Drug Plan and are qualified for program assistance, you will: (i) be eligible to obtain the medication from the program for a calendar year term (ii) not purchase this medication under your Medicare plan while enrolled in the program; (iii) not submit claims nor seek true out-of-pocket (TrOOP) credit for the medication provided during your enrollment. If you have questions, want to update your information, or terminate your enrollment, please call 1-833-4SANDOZ (1-833-472-6369).

I confirm the information I provided is complete and accurate and that I have read and agree to the Patient Authorization and the Terms & Conditions on pages 3 and 4.

Patient Name *(print)*: _____

Patient Sign Here: _____ **Date** *(mm/dd/yyyy)*: _____
(REQUIRED) **(REQUIRED)**

If patient is a minor, patient's Parent/Guardian must sign below:

Parent/Guardian: _____ **Date** *(mm/dd/yyyy)*: _____

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TO BE COMPLETED BY HEALTH CARE PROVIDER: All information is required.

Reason for patient applying to SPA: ☐ No Insurance Coverage ☐ Co-pay unaffordable for patient ☐ Drug not covered

1. Prescription *(Please complete a copy of this page for each medication and dosage strength you are requesting.)*

Patient First Name: _____ **Patient Last Name**: _____

Date of Birth (*mm/dd/yyyy*): _____ **ICD Code**: _____

Name of Product: _____ **Strength**: _____

Sig: _____ **Quantity**: _____ **Day Supply**: _____

First Time Fill: ☐ Yes ☐ No **Number of Refills** *(maximum 11)*: _____ **Anticipated First Fill Date**: _____

Patient Allergies: _____ or ☐ none

List of Patient's Current Medications: _____ or ☐ none

2. HCP Information *(The address you provide here will be used to ship infused medications. Self-administered medications will be shipped directly to the Patient.)*

First Name: _____ **Last Name**: _____

Site Name: _____ **Site Contact**: _____

Address Line 1: _____ **Address Line 2**: _____

City: _____ **State**: _____ **Zip Code**: _____

Phone: _____ **Fax**: _____ **Email**: _____

Tax ID #: _____ **NPI #**: _____

State License #: _____ **Expiration** (mm/yyyy): _____ **DEA #**: _____

Provider Transaction Access Number (PTAN) *(required if the patient has Medicare)*: _____

3. Prescriber Certification and Signature

I certify that the above therapy is medically necessary, and that this information is accurate to the best of my knowledge. I authorize Sandoz as my designated agent for the purposes of performing any steps necessary to obtain reimbursement for the medication indicated, including but not limited to insurance verification, conducting a benefits verification, and/or investigation, case assessment, using this form to obtain necessary information from the above-named patient's insurer and I authorize Sandoz Patient Assistance (SPA), Sandoz, or its affiliated companies or subcontractors, including in-network specialty pharmacy for the above-named patient. In addition, I certify and warrant the following: This request has been prepared exclusively by me or my office. I have obtained written authorization from the patient identified in this request to disclose the patient's personal health information (PHI), including information relating to the patient's medical condition and prescription medications and the information disclosed in this patient's enrollment form, as well as the information included in this request to Sandoz for the purpose of application and enrollment in SPA. I have provided the patient with the notices necessary to comply with all federal and state laws related to the privacy of health information, including but not limited to HIPAA. I further certify that (a) any service provided through Sandoz on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use the medication indicated or any other Sandoz product or service for anyone, and (b) my decision to prescribe the above medication was based solely on my determination of medical necessity as set forth herein. I will not submit an insurance claim or other claim for reimbursement to any government or true out-of-pocket costs (TrOOP). I will notify Sandoz immediately if I become aware that this patient's insurance or income status has changed. I verify that the information I have provided is accurate and complete to the best of my knowledge.

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 SPA is exclusively for purposes of patient care and not remuneration of any sort. I understand that SPA may revise, change, or terminate programs at any time. I have discussed SPA with my patient, who has authorized me under HIPAA and state law to disclose their information to SPA for limited purpose of enrolling in the program. To complete this enrollment, SPA may contact the patient by phone or letter.

My signature below indicates that I have read, understand, and agree to the Health Care Provider Authorization and the above prescription.

_____ **Date** (*mm/dd/yyyy*): _____

Health Care Provider Signature

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