KISQALI® (ribociclib)
Patient Reimbursement Request Form

To see if Novartis Patient Support can reimburse you for medication or treatment, please:

1. Fill out the Patient Information section below.
2. Provide a copy of the front and back of your prescription card.
3. Sign the Certification Statement at the end of this form.
4. Mail or fax your request, receipts, and this form to:
   Novartis Patient Support Claims Processing Department
   430 Mountain Avenue, Suite 105, New Providence, NJ 07974
   Fax: 1-631-822-2893

Patient Information*

Last Name:		First Name:		
Address 1:		Address 2:		
City:		State:		ZIP Code:
Date of Birth:		Phone Number:		
Sex for Clinical Use:	☐ Male ☐ Female	Amount Paid ($):		
Group #:		Rx ID #:		

*All Patient Information fields are required

Helpful Tip

You can find your Co-Pay Plus† Group # and Rx ID # in Novartis Patient Support communications

Supporting Materials

If you are submitting for reimbursement for a claim from a pharmacy, please provide:

Original pharmacy receipt and invoice. It must include:

- Patient name and address
- Pharmacy name, address, and phone number
- Health care provider name, address, and phone number
- Prescription number, fill date, drug name, strength, National Drug Code (NDC) number, and quantity
- Overall prescription price and co-pay amount paid
- A copy of the front and back of your prescription card

Last Name:		First Name:	

Mail or fax this completed form and supporting materials to:

Novartis Patient Support Claims Processing Department
430 Mountain Avenue, Suite 105, New Providence,
NJ 07974
Fax: 1-631-822-2893

Questions? Your Novartis Patient Support team can help. Call 1-866-370-7528

Don't Forget!

If you don't include all the required information, your claim will be rejected

Co-Pay Plus Terms & Conditions

†**Limitations apply.** Valid only for those with private insurance. The Program includes the Co-Pay Plus offer, Plus Card (if applicable), and Rebate, with a combined annual limit up to $15,000. 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 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. 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 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 and Puerto Rico. For purchases of FEMARA only, this offer is NOT valid for Massachusetts patients and is only valid for California patients that meet additional eligibility criteria. 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.

Patient Certification Statement

I certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by insurance, a flexible spending account (FSA), health savings account (HSA), or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, VA, DoD, or any other government (state or federally funded) program and that my use of this form is not prohibited by federal or state law. I understand and agree that I am liable for any misrepresentations herein to the full extent of applicable law.

Acknowledged and agreed (patient/caregiver signature required): _____ Date: _____

Please allow 7-10 business days for processing and payment of claims.

NOVARTIS