Universal Co-pay Program (UCP) Assistance Request Form

Here is the form you requested from Novartis Pharmaceuticals Corporation.
To receive your co-pay assistance check for eligible co-pay expenses within 7 to 10 days for a valid prescription filled within the past 180 days, please complete the following 5 steps:

1. Fill out Patient Information
2. Fill out Co-pay Card Information
3. Read Terms and Conditions on page 2
4. Complete and sign Certification Statement
5. Mail or fax this form along with the items listed on page 2 of this form

STEP 1 | Patient Information (please print)

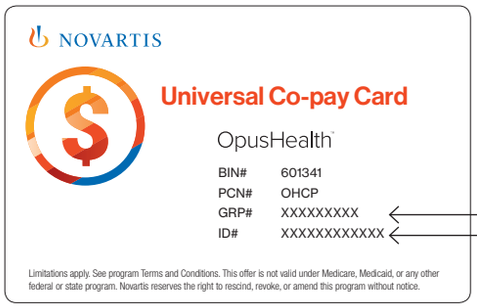
Last Name: _____ First Name: _____

Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Date of Birth: ____/____/____

Phone #: _____

STEP 2 | Universal Co-pay Card Information



GRP #:

☐☐☐☐☐☐☐☐☐

(This 9-digit # can be found beneath the PCN # on the front of your Universal Co-pay Card)

ID #:

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(This 12-digit # can be found beneath the GRP # on the front of your Universal Co-pay Card)

STEP 3 | Read Terms and Conditions on page 2

STEP 4 | Sign Certification Statement

I, _____, certify that my prescription medication for which I am seeking co-pay assistance is not paid for, in whole or in part, by any state or federal government program. The information I am providing on or in connection with this co-pay assistance request form is accurate to the best of my knowledge, and the medication co-pay expenses for which I am seeking co-pay assistance were actually incurred. I agree to the Terms and Conditions of the program, which are provided on this form.

Patient Signature: _____ **Date:** _____

STEP 5 | **Co-pay Assistance Request**

For medication co-pay assistance, send this completed form, along with the items listed below, via mail or fax.

1. A photocopy of the front and back of your **Universal Co-pay Card**
2. A photocopy of the front and back of your **primary insurance card** for prescription drugs
3. A copy of the proof of payment and original pharmacy receipt, or invoice which must show: NDC, quantity, date of fill, and out-of-pocket expenses incurred

Mail: Novartis Oncology Claims
Processing Department
c/o IQVIA
77 Corporate Drive
Bridgewater, NJ 08807

Fax: 1-973-781-4000

For questions about the Universal Co-pay Program, the program offer, or this form, please call 1-877-577-7756.

The personal information that you supply on this form will be used only for the purpose of the co-pay assistance request and inquiries and may be disclosed to third parties acting on behalf of the manufacturer to support this.

Terms and Conditions: Under the Terms and Conditions of this program, the patient is responsible for a portion of their copayment for their prescribed medication, which varies based on the medication. After the patient pays such amount, Novartis will pay their remaining co-pay up to the combined annual limit, which also varies based on the medication. Please see Copay.NovartisOncology.com to understand the patient responsibility and combined annual limit for the medication you are prescribed. The Novartis Oncology Universal Co-pay Program includes the co-pay card, payment card, or rebate. Patient is responsible for any costs once the limit is reached in a calendar year. This offer is only available to patients with private insurance. The program is not available for patients who: (i) are enrolled in Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program; (ii) are not using insurance coverage at all; (iii) are enrolled in an insurance plan that 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 enrolled patients and is intended to be credited toward patient out-of-pocket obligations, including applicable copayments, coinsurance, and deductibles. Proof of purchase may be required. 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 his/her health plan related to the use of the program. Program is not valid where prohibited by law. Valid only in the United States and Puerto Rico. For certain medications, 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. This program may not be combined with any third-party rebate, coupon, or offer. Novartis reserves the right to rescind, revoke, or amend the program and discontinue support at any time without notice.

Non-marketing TCPA Consent:

By providing my information, I agree to be contacted by mail, email, telephone calls and text messages at the numbers and addresses provided in this enrollment. I also agree to be contacted by telephone calls and text messages made by or using automatic telephone dialing machines or artificial or prerecorded voice, at the number(s) provided in this enrollment, 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 email address(es) provided, and I agree to notify the Companies promptly if any of my number(s) or address(es) change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that the Companies do 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 email and cell phone cannot be secured against unauthorized access.

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