Novartis Patient Support™

KISQALI® (ribociclib) START FORM

* = REQUIRED FIELDS

☐ **Electrocardiogram (ECG) Testing Support Only:**
Check this box and complete all highlighted fields below if you would like to enroll your patient in ECG testing support only (and no other services).

Please fill out all fields on this form to enroll in Novartis Patient Support.

1. Patient Information

Please indicate your patient type: ☐ New ☐ Existing

First Name* | Last Name* | Email

Date of Birth (MM/DD/YYYY)* | Sex for Clinical Use*: ☐ Male ☐ Female | Phone Number*† — *We'll keep you updated through non-marketing calls and texts.* ☐ Mobile ☐ Home

Address (No PO Box)* | OK to Leave Voicemail: ☐ Yes ☐ No

City | State | ZIP | Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

I give permission to disclose my personal health information to the following Caregiver (optional):

Caregiver Name | Relationship to Patient

Caregiver Phone Number — *We'll keep you updated through non-marketing calls and texts.*

2. Patient Authorization and Additional Enrollment Consents

I have read and agree to the Patient Authorization on page 3.

X _____

Patient/Authorized Representative Signature* | **Date (MM/DD/YYYY)**

☐ Check here if signed by an Authorized Representative.

CO-PAY PLUS‡
Pay as little as $0.

☐ I have read and agree to the Co-Pay Plus Terms and Conditions on page 3.

ONGOING SUPPORT FROM NOVARTIS PATIENT SUPPORT
You can also get continued one-on-one support from your dedicated Novartis Patient Support Team by checking the box below.

☐ I agree to receive marketing calls and texts from and on behalf of Novartis and its affiliates, including calls and texts made with an autodialer or prerecorded voice, at the phone number(s) I provide. I understand that my consent is not required and is not a condition of receiving any goods or services from Novartis.

3. Insurance Information

Please include copies (front and back) of the patient's medical and prescription insurance card(s). Include primary, secondary, and prescription insurance.

Check all that apply*: ☐ Primary ☐ Secondary ☐ Prescription ☐ Patient Is Uninsured

4. Prescriber Information

First Name* | Last Name* | Practice Name*

Address | Practice Phone Number

City | State | ZIP* | Office Contact Name | Office Contact Phone

Prescriber NPI Number* | Office Fax*

Tax ID Number | State License Number | Office Email

Send Fax
800-414-3518

Questions? Call
866-433-8000

Complete entire form and fax to Novartis Patient Support at 800-414-3518.
An incomplete Start Form may delay the start of treatment.

5. Electrocardiogram (ECG) Testing Support

If you are requesting ECG testing support, where will your patient complete their first ECG? ☐ In-home ☐ In-office ☐ ECG support not needed

Do you need a portable ECG device provided to your office? ☐ Yes ☐ No

6. Preferred Specialty Pharmacy

Please indicate where you would like the prescription triaged.

☐ No preference: Please send the prescriptions to the patient's payer-mandated specialty pharmacy

☐ On-site dispense: Please send the prescription to our office for dispense

_____ **Preferred Pharmacy Phone Number** _____ **Preferred Pharmacy Fax**

☐ Preferred Specialty Pharmacy: Please send the prescription to the specialty pharmacy listed below

_____ **Preferred Specialty Pharmacy Name** _____ **Specialty Pharmacy Phone Number** _____ **Specialty Pharmacy Fax Number**

7. Primary Diagnosis Codes:

☐ HR+, HER2- Advanced or Metastatic Breast Cancer ☐ HR+, HER2- Early Breast Cancer

Primary ICD-10-CM Code*: _____

Secondary ICD-10-CM Code (if applicable): _____

8. Pharmacy Prescription

For advanced or metastatic breast cancer, the recommended starting dose is 600 mg. For early breast cancer, the recommended starting dose is 400 mg. Please select the appropriate dose for your patient in the table below by checking a single box in each applicable column:

PRODUCT INFORMATION:	**DOSING** (Please choose 1 of the following dose packs)	**QUANTITY**	**REFILLS**
☐ **TABLETS** **KISQALI® (ribociclib)** tablet 200 mg	☐ KISQALI 600 mg Dose Pack: 3 tablets per day	KISQALI packaging comes in 28-day cycle packs, which include a 21-day supply of tablets, followed by 7 days off.	____ refills
	☐ KISQALI 400 mg Dose Pack: 2 tablets per day		
	☐ KISQALI 200 mg Dose Pack: 1 tablet per day		

Prescriber Attestation

I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the prescriber who has prescribed KISQALI to the patient named on this form. I certify that any medication received from Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") or the Novartis Patient Assistance Foundation, Inc., and its service providers ("NPAF"), will be used only for the patient named on this form and will not be offered for sale, trade, or barter, returned for credit, or submitted for reimbursement in any form. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Novartis and NPAF may revise, change, or terminate their respective programs at any time.

I have discussed the Novartis Patient Support Program with my patient, who has authorized me under HIPAA and state law to disclose their information to Novartis for the limited purpose of enrolling in Novartis Patient Support. To complete this enrollment, Novartis may contact the patient by phone, text, and email.

→ **X** _____ _____ _____ ___/___/___

Prescriber Signature (Dispense as Written) (Substitution Permissible) **Prescriber Name** (Print Name)* **Date (MM/DD/YYYY)***

ATTN: Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).

Send Fax 800-414-3518 **Questions? Call** 866-433-8000

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Novartis
Patient Support

Patient Authorization.

I authorize my healthcare 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., and its service providers ("NPAF") 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 copay 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.

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 healthcare providers may receive payment from Novartis or NPAF for providing certain 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 can cancel this Authorization at any time by calling 866-433-8000 or by writing to:

Novartis Patient Support
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 Provider's 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.

‡Co-Pay Plus Terms and Conditions

Co-Pay Plus: 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.

Bridge Program: The Bridge Program applies to KISQALI and the KISQALI FEMARA Co-Pack only. Eligible patients must have private insurance, a valid prescription for KISQALI or the KISQALI FEMARA Co-Pack, and a denial of insurance coverage based on a prior authorization requirement. Program requires the submission of a prior authorization and/or appeal of the coverage denial within the first 90 days of enrollment to remain eligible. Program provides KISQALI for free to eligible patients for up to 5 months, or until they receive insurance coverage approval, whichever occurs earlier. A valid prescription consistent with FDA-approved labeling is required. Program is not available to patients whose medications are reimbursed in whole or in part by Medicare, Medicaid, TRICARE, or any other federal or state program. Patients may be asked to reverify insurance coverage status during the course of the program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Additional Limitations may apply. Novartis Pharmaceuticals Corporation reserves the right to rescind, revoke, or amend this Program without notice.

†Novartis Patient Support may call and text you at the numbers provided for non-marketing purposes (e.g., to help you access and start on KISQALI). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 866-433-8000.

Please see the Novartis Pharmaceuticals Corporation Privacy Policy at http://www.novartis.com/us-en/privacy.

NOVARTIS

KISQALI® ribociclib 200 mg tablets

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080