Cosentyx® Connect
REAL SUPPORT. PERSONAL SOLUTIONS.

START FORM

All fields REQUIRED, unless noted.

02.2022 UPDATE EMA

FAX TO: 1-844-666-1366
Or 1-800-343-9117
PHONE: 1-844-267-3689
For Electronic Enrollment, visit: **www.CoverMyMeds.com**

1. PATIENT INFORMATION *(Section 1 to be completed and signed by Patient or Parent/Legal Guardian)* – REQUIRED

Patient's Name (First, Middle, Last) _____ DOB (MM/DD/YYYY) _____ Sex ☐ M ☐ F

Authorized Representative (First, Middle, Last) _____ Relationship to Patient _____

Address _____ City _____ State _____ ZIP _____

Cell Phone _____ ☐ OK to leave message about COSENTYX® Secondary Phone _____ ☐ OK to leave message about COSENTYX

Email (required for co-pay enrollment) _____ Preferred Language ☐ English ☐ Spanish ☐ Other _____

Patient Authorization (required)
I confirm that the information provided herein is truthful and accurate to the best of my knowledge.
☐ **I have read and agree to the Terms and Conditions for the Co-pay Assistance Program on page 3.**
The COSENTYX® Connect program includes calls and texts to help you get started on COSENTYX. After you fill your prescription, you will receive reminders, education, and lifestyle tips by mail and email. You can also get this ongoing support via calls and texts by checking the box below.
☐ **I agree to receive recurring reminders, tips, and more via calls and texts at the phone number provided. I understand calls or texts may be autodialed or prerecorded and are not a condition of purchase.** (Optional, please see page 3)

Novartis Patient Assistance Foundation, Inc. (NPAF) provides free medication to eligible uninsured and underinsured patients experiencing financial hardship. Proof of income is required. If you choose to apply for free medication, checking the box below will prompt NPAF to verify your income.
☐ **I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization on page 3.** (Optional)

PATIENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____ (MM/DD/YYYY)
I have read and agree to the Patient Authorization on page 2.
CANNOT PROCESS FORM WITHOUT SIGNATURE AND DATE

2. INSURANCE INFORMATION *(Section 2 to be completed by Patient or Parent/Legal Guardian)* – REQUIRED

Please check appropriate box: ☐ Uninsured ☐ Insured If insured, please check one: ☐ Provide Information Below **Or** ☐ Copy of Primary Medical and Prescription Cards Attached (Front & Back)

Beneficiary/Cardholder Name _____ Prescription Insurance _____

Primary Health Insurance _____ Phone # _____ Rx Group # _____

Primary Health Insurance ID _____ Rx ID# _____

Group # _____ Rx BIN # _____ Rx PCN # _____

FOR HEALTHCARE PROVIDER USE ONLY

3. PRESCRIBER INFORMATION *(Sections 3–7 to be completed by the prescriber)* – REQUIRED EXCEPT WHERE NOTED

Prescriber's Name _____ Site Institution Name (optional) _____

NPI # _____ Collaborating MD/DO _____

Address _____ City _____ State _____ ZIP _____

Office Contact Name _____ Office Phone _____ Office Fax _____

Office Email (optional) _____

4. CLINICAL INFORMATION – REQUIRED

Primary Diagnosis/ICD-10-CM Codes: (check one) – REQUIRED ☐ L40.0 Plaque Psoriasis ☐ L40.5 Psoriatic Arthritis ☐ L40.54 Psoriatic juvenile arthropathy
☐ M08.90 Juvenile arthritis, unspecified ☐ M45.0 Ankylosing Spondylitis ☐ M45.A Non-Radiographic Axial Spondyloarthritis ☐ Other ICD-10-CM Code(s): _____

Secondary Diagnosis/Special Areas or Manifestations (optional) _____

Has patient participated in a COSENTYX clinical trial? ☐ Yes ☐ No The patient has previously been treated with a biologic for the diagnosed condition. ☐ Yes ☐ No

If patient has been treated with a biologic or another therapy, please answer the following questions:

Excluding COSENTYX, does this patient have a contraindication, intolerance, or allergy to Cimzia®, Enbrel®, Humira®, Remicade®, Simponi®, Stelara®, Taltz®, or other biologic treatments, or to phototherapy, methotrexate, sulfasalazine, NSAIDs (diclofenac, ibuprofen, etc)? ☐ Yes _____ ☐ No

Excluding COSENTYX, does this patient have documented efficacy failure of adequate trial on NSAIDs, DMARDs, or other treatments? ☐ Yes ☐ No

If YES, please indicate which drug(s):

☐ Cimzia® ☐ Enbrel® ☐ Humira® ☐ Otezla® ☐ Remicade® ☐ Rinvoq® ☐ Simponi® ☐ NSAIDs (diclofenac, ibuprofen, etc)
☐ Skyrizi® ☐ Stelara® ☐ Taltz® ☐ Tremfya® ☐ Phototherapy ☐ Methotrexate ☐ Sulfasalazine ☐ Other _____

5. SELECT PRESCRIPTION TYPE – REQUIRED

PLEASE CHECK PRESCRIPTION TYPE (MUST CHECK BOTH TO FILL PHARMACY AND BRIDGE RX):
☑ **PHARMACY PRESCRIPTION** ☐ **COVERED UNTIL YOU'RE COVERED FREE MEDICATION PRESCRIPTION (TERMS AND CONDITIONS APPLY*)**

SHIP TO INFORMATION FOR COVERED UNTIL YOU'RE COVERED FREE MEDICATION PRESCRIPTION – REQUIRED
FIRST DOSE, SHIP TO: ☐ Patient ☐ Office, as allowable by law **ALL SUBSEQUENT DOSES WILL BE SHIPPED TO THE PATIENT**

6. PHARMACY PRESCRIPTION – REQUIRED

Patient Weight: _____ kg / lbs **(circle one unit of measure)** **Date Weight Obtained:** _____

HCP Preferred Specialty Pharmacy (optional): _____ ☐ The patient prescription has been sent to the specialty pharmacy noted here

Adult			Dosing	Qty	Refills
COSENTYX 150 mg	☐ Sensoready® (1x150 mg/mL)	☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____
COSENTYX 300 mg	☐ Sensoready (2x150 mg/mL)	☐ Prefilled Syringe (2x150 mg/mL)	☐ **Loading Dose:** Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____
Pediatric			**Dosing**	**Qty**	**Refills**
COSENTYX 75 mg (wt <50 kg)		☐ Prefilled Syringe (1x75 mg/mL)	☐ **Loading Dose:** Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____
COSENTYX 150 mg (wt ≥50 kg)	☐ Sensoready (1x150 mg/mL)	☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____

***COVERED UNTIL YOU'RE COVERED PROGRAM: Eligible patients must have commercial insurance, a valid prescription for COSENTYX, and a denial of insurance coverage based on prior authorization request. Program requires the submission of an appeal within 90 days after enrollment. See Program Terms and Conditions on page 3.** I understand that the Covered Until You're Covered Program is designed to support patients who are denied insurance coverage for COSENTYX for up to two years until such coverage is secured, and I confirm that I will support the above identified patient in seeking to secure such coverage as I deem appropriate. I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed COSENTYX to the previously identified patient. **I have discussed the COSENTYX® Connect 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 COSENTYX® Connect. To complete this enrollment, Novartis may contact the patient by phone, text, and/or email.** I also agree to receive communications, including faxes, related to my patient's enrollment or participation in the COSENTYX® Connect Program. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. I authorize Novartis Pharmaceuticals Corporation and its service providers, and the Novartis Patient Assistance Foundation, Inc. (NPAF) and its service providers to transmit the above prescription by any means allowed under applicable law to the appropriate specialty pharmacy for my patient. I agree to the NPAF Authorization on page 3.

CANNOT PROCESS FORM WITHOUT A SIGNATURE AND DATE

PRESCRIBER SIGNATURE _____ DATE _____ (MM/DD/YYYY)
Dispense as Written (No Stamps)

OR

PRESCRIBER SIGNATURE _____ DATE _____ (MM/DD/YYYY)
Substitution Permitted (No Stamps)

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

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

Please read the following carefully, then sign and date where indicated on page 1.

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 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

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 aspects 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 that 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 1-844-267-3689 or writing to:

Cosentyx® Connect Patient Support Program
PO Box 2953
Phoenix, AZ 85062-2953

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

Please visit the Novartis website: https://www.novartis.us.

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

Telephone Consumer Protection Act (TCPA) Consent (Optional)

The COSENTYX® Connect program includes calls and texts to help you get started on COSENTYX®. After you fill your prescription, you will receive reminders, education, and lifestyle tips by mail and email. You can also get this ongoing support via calls and texts by checking the box in section 1 on the Enrollment and Prescription Form. By checking said box, you also acknowledge your understanding that calls or texts may be autodialed or prerecorded and are not a condition of purchase. I agree to the TCPA Terms & Conditions. Number of messages will vary based on my program selections. Message and data rates may apply. I understand that I can read the full Novartis Pharmaceuticals Corporation Privacy Policy at www.usprivacy.novartis.com. Text STOP to opt out and HELP for help.

Co-pay Assistance Program Terms and Conditions

Limitations apply. Valid only for those with private insurance. The COSENTYX Co-pay Program includes the Co-pay Card, Payment Card (if applicable), and Rebate, with a combined annual limit up to $16,000. 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 healthcare 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 healthcare 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 US and Puerto Rico. 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.

Covered Until You're Covered Program Terms and Conditions

Eligible patients must have commercial insurance, a valid prescription for COSENTYX, and a denial of insurance coverage based on a prior authorization request. Program requires the submission of an appeal of the coverage denial within the first 90 days of enrollment in order to remain eligible. Program provides initial 5 weekly doses (if prescribed) and monthly doses for free to patients for up to two years or until they receive insurance coverage approval, whichever occurs earlier. 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. Limitations may apply. Enrolled patients awaiting coverage for COSENTYX after two years may be eligible for a limited Program extension. Novartis Pharmaceuticals Corporation reserves the right to rescind, revoke, or amend this Program without notice.

Fair Credit Reporting Act (FCRA) Authorization

I understand that I am providing "written instructions" authorizing the Novartis Patient Assistance Foundation (NPAF) and its vendors, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for programs administered by NPAF. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process.

Novartis Patient Assistance Foundation (NPAF) Authorization FOR PHYSICIAN

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge. I certify that I am the physician who has prescribed the drug identified above to the previously identified patient. For the purposes of transmitting this prescription, I authorize NPAF and its affiliates, business partners, and agents to forward as my agent for these limited purposes this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. 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 NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that NPAF may revise, change, or terminate programs at any time.

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

EXAMPLE FORM

Cosentyx® Connect
REAL SUPPORT. PERSONAL SOLUTIONS.

START FORM

All fields REQUIRED, unless noted.

02.2022 UPDATE EMA

FAX TO: 1-844-666-1366
Or 1-800-343-9117
PHONE: 1-844-267-3689
For Electronic Enrollment, visit: www.CoverMyMeds.com

1. PATIENT INFORMATION *(Section 1 to be completed and signed by Patient or Parent/Legal Guardian)* – REQUIRED

Patient's Name (First, Middle, Last) Jane A. Doe DOB (MM/DD/YYYY) 09/27/1963 Sex ☐ M ☑ F

Authorized Representative (First, Middle, Last) Jen B. Sample Relationship to Patient Parent

Address 1246 Hanson Way City Raleigh State NC ZIP 23645

Cell Phone 919-123-5555 ☑ OK to leave message about COSENTYX® Secondary Phone 919-123-4567 ☑ OK to leave message about COSENTYX

Email (required for co-pay enrollment) JDoe@yahoo.com Preferred Language ☑ English ☐ Spanish ☐ Other

Patient Authorization (required)

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

☑ **I have read and agree to the Terms and Conditions for the Co-pay Assistance Program on page 3.**

The COSENTYX® Connect program includes calls and texts to help you get started on COSENTYX. After you fill your prescription, you will receive reminders, education, and lifestyle tips by mail and email. You can also get this ongoing support via calls and texts by checking the box below.

☑ **I agree to receive recurring reminders, tips, and more via calls and texts at the phone number provided. I understand calls or texts may be autodialed or prerecorded and are not a condition of purchase.** (Optional, please see page 3)

Novartis Patient Assistance Foundation, Inc. (NPAF) provides free medication to eligible uninsured and underinsured patients experiencing financial hardship. Proof of income is required. If you choose to apply for free medication, checking the box below will prompt NPAF to verify your income.

☑ **I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization on page 3.** (Optional)

PATIENT/LEGAL GUARDIAN SIGNATURE *Jane Doe* DATE *01/15/2022* (MM/DD/YYYY)

I have read and agree to the Patient Authorization on page 2.

CANNOT PROCESS FORM WITHOUT SIGNATURE AND DATE

2. INSURANCE INFORMATION *(Section 2 to be completed by Patient or Parent/Legal Guardian)* – REQUIRED

Please check appropriate box: ☐ Uninsured ☑ Insured If insured, please check one: ☑ Provide Information Below **Or** ☐ Copy of Primary Medical and Prescription Cards Attached (Front & Back)

Beneficiary/Cardholder Name Jane A. Doe Prescription Insurance Express Scripts

Primary Health Insurance Blue Cross Blue Shield Phone # 1-866-966-5777 Rx Group # 12345

Primary Health Insurance ID YPYW12345678 Rx ID# 12345

Group # 12345 Rx BIN # 12345 Rx PCN # 12345

FOR HEALTHCARE PROVIDER USE ONLY

3. PRESCRIBER INFORMATION *(Sections 3–7 to be completed by the prescriber)* – REQUIRED EXCEPT WHERE NOTED

Prescriber's Name John Doe, MD Site Institution Name (optional) Raleigh Dermatology

NPI # 123456789 Collaborating MD/DO

Address 1468 Raleigh Rd. City Raleigh State NC ZIP 27529

Office Contact Name Beth Dunn Office Phone 919-333-5323 Office Fax 919-212-1221

Office Email (optional) BDunn@RaleighDerm.com 123456789

4. CLINICAL INFORMATION – REQUIRED

Primary Diagnosis/ICD-10-CM Codes: (check one) – REQUIRED ☑ L40.0 Plaque Psoriasis ☐ L40.5 Psoriatic Arthritis ☐ L40.54 Psoriatic juvenile arthropathy

☐ M08.90 Juvenile arthritis, unspecified ☐ M45.0 Ankylosing Spondylitis ☐ M45.A Non-Radiographic Axial Spondyloarthritis ☐ Other ICD-10-CM Code(s):

Secondary Diagnosis/Special Areas or Manifestations (optional)

Has patient participated in a COSENTYX clinical trial? ☐ Yes ☑ No The patient has previously been treated with a biologic for the diagnosed condition. ☑ Yes ☐ No

If patient has been treated with a biologic or another therapy, please answer the following questions:

Excluding COSENTYX, does this patient have a contraindication, intolerance, or allergy to Cimzia®, Enbrel®, Humira®, Remicade®, Simponi®, Stelara®, Taltz®, or other biologic treatments, or to phototherapy, methotrexate, sulfasalazine, NSAIDs (diclofenac, ibuprofen, etc)? ☐ Yes ☑ No

Excluding COSENTYX, does this patient have documented efficacy failure of adequate trial on NSAIDs, DMARDs, or other treatments? ☑ Yes ☐ No

If YES, please indicate which drug(s):

☐ Cimzia® ☐ Enbrel® ☐ Humira® ☐ Otezla® ☐ Remicade® ☐ Rinvoq® ☐ Simponi® ☐ NSAIDs (diclofenac, ibuprofen, etc)

☐ Skyrizi® ☐ Stelara® ☐ Taltz® ☐ Tremfya® ☑ Phototherapy ☑ Methotrexate ☐ Sulfasalazine ☐ Other

5. SELECT PRESCRIPTION TYPE – REQUIRED

PLEASE CHECK PRESCRIPTION TYPE (MUST CHECK BOTH TO FILL PHARMACY AND BRIDGE RX):

☑ **PHARMACY PRESCRIPTION** ☑ **COVERED UNTIL YOU'RE COVERED FREE MEDICATION PRESCRIPTION (TERMS AND CONDITIONS APPLY*)**

SHIP TO INFORMATION FOR COVERED UNTIL YOU'RE COVERED FREE MEDICATION PRESCRIPTION – REQUIRED

FIRST DOSE, SHIP TO: ☐ Patient ☑ Office, as allowable by law **ALL SUBSEQUENT DOSES WILL BE SHIPPED TO THE PATIENT**

6. PHARMACY PRESCRIPTION – REQUIRED

Patient Weight: 198 kg /(lbs) **(circle one unit of measure)** **Date Weight Obtained:** 2/7/2022

HCP Preferred Specialty Pharmacy (optional): ☐ The patient prescription has been sent to the specialty pharmacy noted here

Adult			Dosing	Qty	Refills
COSENTYX 150 mg	☐ Sensoready® (1x150 mg/mL)	☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____
COSENTYX 300 mg	☑ Sensoready (2x150 mg/mL)	☐ Prefilled Syringe (2x150 mg/mL)	☑ **Loading Dose:** Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3 ☑ **Maintenance:** Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO 11
Pediatric			**Dosing**	**Qty**	**Refills**
COSENTYX 75 mg (wt <50 kg)		☐ Prefilled Syringe (1x75 mg/mL)	☐ **Loading Dose:** Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____
COSENTYX 150 mg (wt ≥50 kg)	☐ Sensoready (1x150 mg/mL)	☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____

***COVERED UNTIL YOU'RE COVERED PROGRAM: Eligible patients must have commercial insurance, a valid prescription for COSENTYX, and a denial of insurance coverage based on prior authorization request. Program requires the submission of an appeal within 90 days after enrollment. See Program Terms and Conditions on page 3.** I understand that the Covered Until You're Covered Program is designed to support patients who are denied insurance coverage for COSENTYX for up to two years until such coverage is secured, and I confirm that I will support the above identified patient in seeking to secure such coverage as I deem appropriate. I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed COSENTYX to the previously identified patient. **I have discussed the COSENTYX® Connect 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 COSENTYX® Connect. To complete this enrollment, Novartis may contact the patient by phone, text, and/or email.** I also agree to receive communications, including faxes, related to my patient's enrollment or participation in the COSENTYX® Connect Program. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. I authorize Novartis Pharmaceuticals Corporation and its service providers, and the Novartis Patient Assistance Foundation, Inc. (NPAF) and its service providers to transmit the above prescription by any means allowed under applicable law to the appropriate specialty pharmacy for my patient. I agree to the NPAF Authorization on page 3.

CANNOT PROCESS FORM WITHOUT A SIGNATURE AND DATE

PRESCRIBER SIGNATURE *Jane Doe* DATE *02/07/2022* (MM/DD/YYYY)

Dispense as Written (No Stamps)

OR

PRESCRIBER SIGNATURE DATE (MM/DD/YYYY)

Substitution Permitted (No Stamps)

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

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Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080