Cosentyx® (secukinumab)

SERVICE REQUEST FORM (SRF) AND PRESCRIPTIONS

All fields required, unless noted.

PHONE: 1-844-267-3689
FAX: 1-844-666-1366
Include copy of the insurance card(s) (front and back) and complete all the information below.

New York prescribers please note: The COSENTYX® Connect Personal Support Program or the Network Specialty Pharmacy will contact you to submit your eRX as they are needed.

1. PATIENT INFORMATION *(Section 1 to be completed and signed by patient)*

Patient's Name (First, MI, Last) _____

DOB (MM/DD/YYYY) _____ Sex: ☐ M ☐ F

Street Address _____

City _____ State _____ Zip Code _____

E-mail (optional) _____

☐ **I have read and agree to the Terms and Conditions for participation in the COSENTYX® Co-pay Assistance Program on page 3.**

Cell Phone _____ Home Phone _____

OK to leave message about COSENTYX® on: ☐ Cell Phone ☐ Home Phone

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Alternate Contact Name _____

Relationship to Patient _____

☐ **If eligible, I would like to be connected with the Patient Assistance Program (PAP) application process.** (optional)

PATIENT/LEGAL GUARDIAN SIGNATURE

(required) **I have read and agree to the Patient Authorization on pages 2 and 3.** **Date (MM/DD/YYYY)**

2. INSURANCE INFORMATION *(Section 2 to be completed by patient)*

Beneficiary/Cardholder Name _____

Primary Insurance _____ Phone # _____

Primary Insurance ID # _____ Group # _____

Prescription Insurance _____ ID # _____

Rx Group # _____ Rx BIN # _____ Rx PCN # _____

Secondary Insurance _____ ID # _____ Group # _____

FOR HEALTHCARE PROVIDER USE ONLY

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

Prescriber's Name (First, Last) _____

Office Phone _____ Office Fax _____

Office Contact Name _____

Office E-mail (optional) _____

Tax ID # _____ NPI # _____

Site Institution Name (optional) _____

Address _____

City _____ State _____ Zip Code _____

4. CLINICAL INFORMATION

PRIMARY DIAGNOSIS/ICD-10 Codes: (check all that apply)

☐ L40.00: (Plaque psoriasis)
☐ L40.50: (Arthropathic psoriasis, unspecified)
☐ L40.59: (Other psoriatic arthropathy)
☐ M45.0: (Ankylosing spondylitis)
☐ Other ICD-10 Code(s): _____

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, please answer the following questions.

Does this patient have a contraindication, intolerance, or allergy to Enbrel®, Humira®, Remicade®, Stelara®, Cimzia®, Simponi®, Taltz®, or other biologic treatment? ☐ YES _____ ☐ NO

Does this patient have documented efficacy failure of adequate trial on Enbrel®, Humira®, Remicade®, Stelara®, Cimzia®, Simponi®, Taltz®, or other biologic treatment? ☐ YES _____ ☐ NO

If YES, please indicate which drug(s) and date(s) of usage.

Enbrel® From: _____ To: _____ Humira® From: _____ To: _____

Remicade® From: _____ To: _____ Stelara® From: _____ To: _____

Cimzia® From: _____ To: _____ Simponi® From: _____ To: _____

Taltz® From: _____ To: _____ Other_____ From: _____ To: _____

5. SHIPPING PREFERENCES and INJECTION TRAINING

FIRST DOSE: ☐ Prescriber Address ☐ Patient Address

FOLLOW-UP DOSES: ☐ Prescriber Address ☐ Patient Address

☐ I also request **supplemental injection training** for this patient.

6. COVERED UNTIL YOU'RE COVERED* FREE MEDICATION PRESCRIPTION (optional)

Covered Until You're Covered Program: Eligible patients must have commercial insurance, a completed Service Request Form for COSENTYX, and be experiencing a delay in obtaining coverage. Program provides initial 5 weekly doses (if prescribed) and monthly doses for free to patients for two years or until they receive insurance coverage approval. **(Please complete steps 1–4 below and sign)**

STEP 1: ☐ **SENSOREADY® PEN** OR ☐ **PREFILLED SYRINGE**

STEP 2: ☐ **Inject 300-mg dose subcutaneously (2 injections of 150 mg)** OR ☐ **Inject 150-mg dose subcutaneously**

STEP 3: **INITIAL WEEKLY LOADING DOSE? (Weeks 0, 1, 2, 3, and 4)** ☐ YES ☐ NO

STEP 4: **# OF MONTHLY REFILLS? (once every 4 weeks)** _____

PRESCRIBER CERTIFICATION

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 and that I provided the patient with a description of the COSENTYX Connect Personal Support Program. I authorize the COSENTYX Connect Personal Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy. I understand that the Covered Until You're Covered Program is designed to support patients who are experiencing a delay in obtaining 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.

PRESCRIBER SIGNATURE

(required) (No Stamp Allowed) Date (MM/DD/YYYY)

7. NETWORK PHARMACY PRESCRIPTION *(Please complete steps 1–4 below and sign)*

Preferred Specialty Pharmacy (optional): _____

STEP 1: ☐ **SENSOREADY® PEN** OR ☐ **PREFILLED SYRINGE**

STEP 2: ☐ **Inject 300-mg dose subcutaneously (2 injections of 150 mg)** OR ☐ **Inject 150-mg dose subcutaneously**

STEP 3: **INITIAL WEEKLY LOADING DOSE? (Weeks 0, 1, 2, 3, and 4)** ☐ YES ☐ NO

STEP 4: **# OF MONTHLY REFILLS? (once every 4 weeks)** _____

PRESCRIBER CERTIFICATION

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 and that I provided the patient with a description of the COSENTYX Connect Personal Support Program. I authorize the COSENTYX Connect Personal Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

PRESCRIBER SIGNATURE

(required) (No Stamp Allowed) Date (MM/DD/YYYY)

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

Patient Authorization

I give permission for my healthcare 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 Novartis Pharmaceuticals Corporation, its affiliates, business partners, and agents (together, the "Novartis Group") so that the Novartis Group can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with COSENTYX, (ii) coordinate my receipt of, and payment for COSENTYX, (iii) facilitate my access to COSENTYX, (iv) provide me with information about COSENTYX, disease awareness and management programs, and educational materials, (v) manage the COSENTYX Connect Personal Support Program, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the COSENTYX Connect Personal Support Program.

I give permission to the Novartis Group to disclose my Personal Information to my HCPs, 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 healthcare providers may receive remuneration (payment) from Novartis Pharmaceuticals Corporation in exchange for disclosing my Personal Information to Novartis Pharmaceuticals Corporation 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 privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization at any time in the future by calling 1-888-NOW-NOVA (1-888-669-6682) or by writing to the Customer Interaction Center, Novartis Pharmaceuticals Corporation, One Health Plaza, East Hanover, NJ 07936-1080.

My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctor(s); however, if I revoke this authorization, I may no longer be eligible to participate in the COSENTYX Connect Personal Support Program. If I revoke this authorization, the Novartis Group 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 my 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 the COSENTYX Connect Personal Support Program may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

(continued on last page)

I agree to be contacted by the Novartis Group by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Service Request Form for all purposes described in this Patient Authorization. I also agree to be contacted by the Novartis Group and on its behalf by telephone calls and text messages made by using an automatic telephone dialing system or prerecorded voice at the number(s) provided on the Service Request 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 the Novartis Group 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 Novartis Pharmaceuticals Corporation 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.

Co-pay Assistance Program Terms and Conditions

I understand that this offer is only valid for those with commercial insurance and who have a valid prescription. I understand that this offer is not valid under Medicare, Medicaid, or any other federal or state program (eg, VA, DoD, Tricare), for cash-paying patients, where product is not covered by patient's commercial insurance, or where the plan reimburses the patient for the entire cost of his/her prescription drug. I also understand that this offer is not valid where prohibited by law and is only valid in the United States and Puerto Rico. Finally, Novartis requires patients to annually re-enroll and re-attest to the program terms and conditions. We may use the information you provide to contact you to remind you that your co-pay assistance is about to expire and to confirm your eligibility to continue participating in co-pay assistance.

*Covered Until You're Covered Program

Eligible patients must have commercial insurance, a completed Service Request Form for COSENTYX, and be experiencing a delay in obtaining coverage. Program provides initial 5 weekly doses (if prescribed) and monthly doses for free to patients for two years or until they receive insurance coverage approval. Enrolled patients awaiting coverage for COSENTYX after two years may be eligible for a limited Program extension subject to approval by Novartis Pharmaceuticals Corporation. 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. No purchase necessary. Participation is not a guarantee of insurance coverage. Once coverage is approved, patients will no longer be eligible. Limitations may apply. Novartis Pharmaceuticals Corporation reserves the right to rescind, revoke, or amend this Program without notice. Enrollment expires 12/31/17.

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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