START FORM
10.2023 UPDATE

Cosentyx® (secukinumab)

(For Office Use Only) Indicate your office's preferred level of engagement from Novartis Patient Support for this patient:

☐ **Subcutaneous use — includes:**
Coverage, Prior Authorization, and Appeals Support:
Support from the initial benefits verification through prior authorization and appeals

☐ **Intravenous use — includes (select one):**
☐ **Coverage, Prior Authorization, and Appeals Support:**
Support from the initial benefits verification through prior authorization and appeals
☐ **Benefits Verification Only:**
Benefits verification without prior authorization or appeals support

1 Patient Information

*** = REQUIRED FIELDS**

For patients younger than 18 years of age, please provide a parent or guardian's phone number.

First Name* _____ Last Name* _____

Date of Birth (MM/DD/YYYY)* ___/___/_____ Sex for Clinical Use: ☐ Male ☐ Female

Address (No PO Box)* _____

City _____ State _____ ZIP* _____

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

Name _____

Phone Number† (We'll keep you updated through non-marketing calls/texts†) _____

Email _____ ☐ Mobile ☐ Home

Phone Number*
(We'll keep you updated through non-marketing calls/texts†) _____

OK to Leave Voicemail: ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Relationship to Patient _____

2 Patient Authorization and Additional Consents*

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

X _____ ___/___/_____

Patient or Authorized Representative Signature — Date (MM/DD/YYYY)

☐ Check here if signed by an authorized representative

Scan the code to learn more about COSENTYX.

PATIENT SUPPORT CO-PAY OFFER

☐ I have read and agree to the $0 Co-Pay Offer Terms and Conditions on page 3.

ONGOING SUPPORT FROM COSENTYX® CONNECT PATIENT SUPPORT

You can get additional one-on-one support, such as recurring reminders, tips, and other communications 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 pharmacy insurance card(s). Include primary, secondary, and pharmacy benefit insurance as applicable.

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

4 Provider Information

First Name* _____ Last Name* _____

Address _____

City _____ State _____ ZIP* _____

Provider NPI Number* _____

Tax ID Number*
(Required to run benefits for IV patients) _____ PTAN Number _____

Practice Name* _____

Practice Phone Number _____

Office Contact Name _____ Office Contact Phone _____

Office Fax* _____

Office Email _____

Send Fax
1-844-666-1366 or 1-800-343-9117

Enroll Online
www.CoverMyMeds.com

Questions? Call
1-844-267-3689

Complete the entire form and fax to COSENTYX® Connect Patient Support at 1-844-666-1366.
An incomplete Start Form may delay the start of treatment.

START FORM
10.2023 UPDATE

Patient Name* _____ Date of Birth (MM/DD/YYYY)* ___/___/___

Cosentyx® (secukinumab)

5 Treating Site Information (IV formulation use only) If you intend to send your patient to another site to receive COSENTYX® (secukinumab) IV formulation, please complete the information below.

Please indicate your preferred alternate site, if any:

☐ Non-Prescribing MD's Office ☐ Hospital Outpatient Facility ☐ Home Infusion/Infusion Provider Company ☐ Other

If alternate site of service is known, please fill out the details below:

Site Name* _____ Expected COSENTYX Treatment Date (MM/DD/YYYY) ___/___/___

Address* _____ Phone _____

City _____ State _____ ZIP* _____ Fax* _____

Site NPI Number* _____ Tax ID Number* _____ Contact Name _____ Contact Phone _____

6 Additional Information*

Primary Diagnosis/*ICD-10-CM* **Codes** (check one)**:** ☐ 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)**:** _____

Excluding COSENTYX, does this patient have a contraindication or have they previously taken any of the following treatments below? If yes, please indicate from the options below: (optional)

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

☐ Skyrizi® ☐ Stelara® ☐ Taltz® ☐ Tremfya® ☐ Phototherapy ☐ Methotrexate ☐ Sulfasalazine ☐ Other, list drug name(s): _____

7 Prescription Information (for subcutaneous use only)*

Covered Until You're Covered Free Medication Prescription

Ship first dose to: ☐ Patient ☐ Office, as allowable by law **All subsequent doses will be shipped to the patient.**

Pharmacy Prescription and Covered Until You're Covered*:

Adult	Dosing (Qty 28 Days)	Refills
COSENTYX 150 mg ☐ Sensoready® Pen (1x150 mg/mL) ☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3	N/A
	☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	☐ 12 refills, or _____ refills
COSENTYX 300 mg ☐ UnoReady® Pen (1x300 mg/2 mL) ☐ Sensoready® Pen (2x150 mg/mL) ☐ Prefilled Syringe (2x150 mg/mL)	☐ **Loading Dose:** Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3	N/A
	☐ **Maintenance:** Inject 300 mg subcutaneously on Week 4, then **every 4** weeks thereafter	☐ 12 refills, or _____ refills
Pediatric	**Dosing (Qty 28 Days)**	**Refills**
COSENTYX 75 mg (wt <50 kg) ☐ Prefilled Syringe (1x75 mg/mL)	☐ **Loading Dose:** Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3	N/A
	☐ **Maintenance:** Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter	☐ 12 refills, or _____ refills
COSENTYX 150 mg (wt ≥50 kg) ☐ Sensoready® Pen (1x150 mg/mL) ☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3	N/A
	☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	☐ 12 refills, or _____ refills

Provider Attestation

Prescriber must authorize these instructions by signing at the end of this section.

I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the provider who has prescribed COSENTYX to the previously identified patient and I provided the patient with a description of COSENTYX® Connect Patient Support. For the purposes of transmitting these prescriptions, I authorize NPAF, Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents to forward as my agent, for these limited purposes, the prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. I will not attempt to seek reimbursement for free product provided to my office. **I have discussed COSENTYX® Connect Patient Support 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 Patient Support. To complete this enrollment, Novartis may contact the patient by phone, text, and/or email.**

→ X _____ _____ _____ _____

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

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

Send Fax
1-844-666-1366 or 1-800-343-9117

Enroll Online
www.CoverMyMeds.com

Questions? Call
1-844-267-3689

Complete the entire form and fax to COSENTYX® Connect Patient Support at 1-844-666-1366.
An incomplete Start Form may delay the start of treatment.

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 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 1-844-267-3689 or by writing to:

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 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.

COSENTYX® Connect Co-Pay Offer Terms & Conditions

Limitations apply. Valid only for those with private insurance. Program provides up to $16,000 annually for the cost of COSENTYX and up to $150 per infusion (up to $1,950 annually) for the cost of administration. Co-pay support for infusion administration cost not available in Rhode Island or Massachusetts. 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.

*The Covered Until You're Covered Program is available for COSENTYX® (secukinumab) subcutaneous injection only. 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 COSENTYX for free to eligible patients for up to two years, 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. 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.

†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 COSENTYX). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 1-844-267-3689.