ENTRESTO® Central Patient Support Program Enrollment Form

FAX TO 1-844-263-5644

Please complete this form to receive Benefit Verification, Prior Authorization, and Appeal support through the Coverage and Access Program (CAP). Additionally, the patient will be automatically enrolled in the 12-Month Lifestyle & Treatment Support program, a personalized support program delivered through phone call, direct mail, email, and text message.

STEP 1 Patient Information (completed by Patient /Legal Guardian)

First Name ____________ Last Name ____________

Date of Birth (MM/DD/YYYY) ____________ Gender: ☐ Male ☐ Female

Address ____________

City ____________ State ____________ ZIP ____________

Home Phone # ____________ Cell Phone # ____________

Email Address ____________

Alternate Contact (first and last name required) ____________ Relationship to patient ____________

☐ OK to discuss my condition and ENTRESTO Central participation with my alternate contact(s)

☐ I have read and agree to the Terms and Conditions for participation in the Co-Pay Assistance Program on page 2

Remember to have the Patient/Legal Guardian sign below (A Patient/Legal Guardian signature is required for all services)

Signature of Patient/Legal Guardian (Required) ____________ Date ____________

I have read and agree to the Patient Authorization on page 2. I have received a prescription for ENTRESTO (sacubitril/valsartan) tablets.

The 12-Month Lifestyle and Treatment Support Program includes calls and texts to help get you started on ENTRESTO. After you fill your prescription, you will receive helpful 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.

STEP 2 Patient Insurance Information

If not covered by prescription insurance, complete the Novartis Patient Assistance Foundation (NPAF) application at www.PAPNovartis.com, or call NPAF at 1-800-277-2254.

Prescription Insurance ____________ Medical Insurance ____________

ID # ____________ Policy # ____________

Rx Group # ____________ Policyholder Name ____________

BIN # ____________ Policyholder Date of Birth (MM/DD/YYYY) ____________

PCN # ____________ Relationship to Patient ____________

Insurance Phone # ____________ Insurance Phone # ____________

Medicare Part D Effective Date (MM/DD/YYYY) ____________ Group # ____________

STEP 3 ENTRESTO Prescriber

Has the patient been prescribed ENTRESTO? ☐ Yes ☐ No

If yes, specify dosage: ☐ 24/26 mg ☐ 49/51 mg ☐ 97/103 mg

Physician First Name ____________ Physician Last Name ____________

Address ____________

City ____________ State ____________ ZIP ____________

Name of Practice or Facility ____________ Specialty: ☐ Cardiologist ☐ Primary care ☐ Other

Office Phone # ____________ Fax # ____________

NPI # ____________

Practice/Facility Contact Name ____________ Contact Phone # ____________

Patient Authorization

I authorize my health care 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") 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, and, if enrolled, administer my participation in any Novartis-sponsored financial assistance 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 may share my Personal Information 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 for providing certain of the Services, such as medication or refill reminders, based on my enrollment or participation. Once my Personal Information is disclosed, 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 I can cancel this Authorization at any time by calling 1-888-669-6682 or writing to

Program Administrator
PO Box 29258
Phoenix, AZ 85038-9258

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, 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 on an authorized, ongoing basis, my cancellation with Novartis 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 non-marketing calls and texts from Novartis, including through an autodialer or prerecorded voice, at the number(s) provided.

http://www.pharma.us.novartis.com/

Co-Pay Assistance Program Terms and Conditions

Limitations apply. Valid only for those with private insurance. The Program includes the Co-Pay Card, Payment Card (if applicable), and Rebate, with a combined annual limit of $3250. 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 copayments, 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. Limitations may apply in CA and MA. 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.

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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