Enrollment Form for ENTRESTO® Central Patient Support Program

Dear Health Care Professional,

Thank you for choosing ENTRESTO Central Patient Support Program. Please take a moment to read through the instructions below to guide you on how to complete our enrollment form.

An incomplete form may lead to delays in processing the request. When all relevant steps are completed and the forms are signed, fax the forms to ENTRESTO Central at 1-844-263-5644.

For insurance coverage investigation, prior authorization/appeals support, and the Commercial Co-Pay Assistance Program, complete Steps 1 to 4, and fax to 1-844-263-5644

Step 1: **Patient Information** – Please complete all relevant information. Patient or Legal Guardian MUST sign this section.
- Alternate contacts may include family/friends who the patient gives permission to speak to ENTRESTO Central on their behalf
- **Required** – For eligible patients who would like to receive a commercial co-pay card in the mail, check the box for ENTRESTO Co-Pay Assistance Program

Step 2: **Patient Insurance Information** – A copy of the patient's insurance cards is acceptable.
- Medical insurance information is required if prescription insurance information is not available
- Check box if patient doesn't have prescription insurance
- If you would like the patient to be considered for Novartis Patient Assistance Foundation, Inc. (NPAF) eligibility, complete Step 5 and 6

Step 3: **Prescriber Information** – Please complete all relevant information regarding the ***Prescribing*** Physician.
- Provide Practice/Facility contact name and best phone number to reach them for questions regarding their patient's case
- Provide the Practice/Facility fax number to send a copy of the results of the patient's insurance coverage

Step 4: **Primary Physician Information** – Complete all relevant information **ONLY** if the primary physician is different than the Prescribing Physician. Example: The Prescriber works in the hospital setting.
- Include office contact name and best phone number to reach them for questions regarding their patient's case
- When completed, both Prescriber and Primary Physician will receive the results of the patient's insurance coverage
- When the Primary Physician is different from the Prescribing Physician, ENTRESTO Central will contact the Primary Physician regarding reimbursement and patient services support

For Novartis Patient Assistance Foundation, Inc. (NPAF), complete Steps 1 to 6

Note: Steps 5 and 6 are **ONLY** required for patients to be considered for NPAF eligibility. The ENTRESTO Central enrollment form (page 2) and NPAF and Fair Credit Reporting Act (FCRA) authorization along with the prescription (page 3) should be completed and faxed together to 1-844-263-5644. Incomplete information may cause a delay in processing.

Step 5: **NPAF and Fair Credit Reporting Act (FCRA) authorization** – Only complete this section to consider patient for NPAF eligibility.
- All information is required

Step 6: **Prescription Information** – Please complete all information, including physician signature.
- Prescription should be completed when considering patient for NPAF eligibility

Step 1: Patient Information (Completed and ***signed*** by patient/legal guardian)

First Name _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Gender: ☐ M ☐ F

Address _____

City _____ State _____ ZIP _____

E-mail Address _____ Cell Phone # _____ Home Phone # _____

Alternate Contact Name _____ Relationship to patient _____

☐ **Ok to speak to Alternate contact(s)**

☐ **I have read and agree to the Terms and Conditions for participation in the [ENTRESTO Co-Pay Assistance Program].**

☐ **I have read and agree to receive text messages and calls as explained in the Telephone Consumer Protection Act (TCPA) Consent on page 5 (optional).**

Patient/Legal Guardian Signature (Required) _____ **Date** _____

I have read and agree to the Patient Authorization on page 4

I have received a prescription for ENTRESTO® (sacubitril/valsartan) tablets

Step 2: Patient Insurance Information (A front and back copy of the patient's insurance cards may be submitted in lieu of filling out this step)

☐ ***Check box if patient does NOT have prescription insurance***

Prescription Insurance _____ Medical Insurance _____

ID# _____ Policy # _____

Rx Group # _____ Policy Holder Name _____

BIN # _____ Policy Holder Date of Birth _____

PCN# _____ Relationship to Patient _____

Insurance Phone # _____ Insurance Phone # _____

Group # _____

Step 3: Prescriber Information

Primary Prescriber First Name _____ Primary Prescriber Last Name _____

Address _____

City _____ State _____ ZIP _____

Name of Practice or Facility _____

Site of Care: ☐ Physician Office ☐ Hospital In-patient ☐ Hospital Out-patient ☐ Urgent Care ☐ Long-Term Care (LTC)

Contact Phone # _____ Fax # _____

NPI # _____ Tax ID # _____

Practice/Facility Contact Name _____ Phone # _____

Practice/Facility E-mail _____

Step 4: Primary Physician Information (Only complete this section when the Prescribing Physician is NOT the patient's Primary Physician)

Physician First Name _____ Physician Last Name _____

Address _____

City _____ State _____ ZIP _____

Name of Practice or Facility _____

Specialty: ☐ Cardiologist ☐ Primary Care ☐ Other

Contact Phone # _____ Fax # _____

NPI # _____ Tax ID # _____

Practice/Facility Contact Name _____ Phone # _____

Practice/Facility E-mail _____

Step 5: NPAF and Fair Credit Reporting Act (FCRA) Authorization

(Only required for patients to be considered for NPAF eligibility)

Information below must be completed by Patient:

Total number of people in the household:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other: _____ Annual Household Income: $ _____

☐ I understand that I am providing "written instructions" authorizing NPAF and its vendor, under the Fair Credit Reporting Act ("FCRA"), to obtain information from my credit profile or other information from Experian Health, 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. I promise that any information, including financial and insurance information that I provide, are complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call NPAF at [insert PAP number]. If eligible, I would like to be considered for programs administered by NPAF.

Step 6: Prescription Information

Information below must be completed by Prescriber:

Patient First Name _____ Patient Last Name _____

Date of Birth (MM/DD/YYYY) _____

Address _____

City _____ State _____ ZIP _____

Rx: ENTRESTO

Dispense # _____

 # Refills _____

Patient Allergies _____

ENTRESTO® (sacubitril/valsartan)

☐ **24/26 mg** ☐ **49/51 mg** ☐ **97/103 mg**

Take one ENTRESTO tablet TWICE DAILY.

If switching from an ACE inhibitor:

Stop taking _____ , wait 36 hours then switch to ENTRESTO
(Medication name)

☐ Dispense as written

Prescriber: Please attach a separate prescription if this section does not comply with your state's prescription law.

I certify that the above therapy is medically necessary and that this information is accurate to the best of my knowledge. I certify that I am the health care professional who has prescribed ENTRESTO to the previously identified patient. For the purposes of transmitting this prescription, I authorize NPAF, Novartis Pharmaceuticals Corporation, 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 the above medication 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.

Prescriber First Name _____ Prescriber Last Name _____

Address _____ City _____

State _____ ZIP _____ Primary Phone # _____

Signature of Physician **(Required)** _____ Date _____

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

Patient Authorization

I give permission for my health care 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 (the "Novartis Group") and to the Novartis Patient Assistance Foundation, Inc. ("NPAF") so that the Novartis Group and NPAF can (i) help verify or coordinate insurance coverage or otherwise obtain payment for my treatment with [ENTRESTO], (ii) coordinate my receipt of, and payment for [ENTRESTO], (iii) facilitate my access to [ENTRESTO], (iv) provide me with information about [ENTRESTO], disease awareness and management programs and educational materials, (v) manage the [ENTRESTO Central], (vi) provide me with adherence reminders and support, (vii) conduct quality assurance, surveys and other internal business activities in connection with [ENTRESTO Central], and (viii) if I choose to apply to programs offered by NPAF, to administer those programs, to send me information about programs that might help me pay for my medicines, to coordinate and share my Personal Information with my health care providers, other programs that might help me pay for medicines, government agencies and insurance companies for purposes of providing or facilitating this assistance.

I give permission to the Novartis Group and NPAF to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above. I also give permission to the Novartis Group and NPAF to combine or aggregate any information collected from me with information the Novartis Group and NPAF may collect about me from other sources for the purpose of providing or administering Program Services.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from the Novartis Group in exchange for disclosing my personal information to the Novartis Group 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 and state privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization with respect to [ENTRESTO Central] at any time in the future by calling [insert number] or by writing to the Customer Interaction Center, Novartis Pharmaceuticals Corporation, One Health Plaza, East Hanover, NJ 07936-1080. I also may revoke (withdraw) this authorization with respect to NPAF at any time in the future by calling [insert PAP number].

My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctors; however, if I revoke this authorization, I may no longer be able to participate in [ENTRESTO Central] and/or programs administered by NPAF. If I revoke this authorization, the Novartis Group and/or NPAF will stop using or sharing my information (except as necessary to end my participation in the program and/or NPAF) but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization.

Please read the following carefully, then sign and date where indicated on page 3.

Patient Authorization (cont)

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 [ENTRESTO Central] and/or programs administered by NPAF may change or end at any time without prior notification.

I understand that I may receive a copy of this authorization.

I agree to be contacted by the Novartis Group and NPAF by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Start Form for all purposes described in this Patient Authorization. I also agree to be contacted by the Novartis Group, NPAF and others on its behalf by telephone calls and text messages made by or using an automatic telephone dialing system or pre-recorded voice, at the number(s) provided on this 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 addresses provided, and I agree to notify the Novartis Group and/or NPAF 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 the Novartis Group and NPAF do 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.

Telephone Consumer Protection Act (TCPA) Consent

I consent to receive marketing and nonmarketing calls and texts from and on behalf of the Novartis Group and NPAF, made with an autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Number of messages will vary based on your program selections; average of [X] messages per week. Message and data rates may apply. Privacy Policy at www.usprivacy.novartis.com. Text STOP to opt out and HELP for help.

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. Additional terms and conditions may apply. Novartis reserves the right to rescind, revoke, or amend the program without notice. Finally, Novartis 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.

NOVARTIS

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