AfiniTRAC® ENROLLMENT FORM

Please complete the entire service request form and fax both pages to 1-877-705-2282.

Hours: Monday – Friday; 8 AM – 8 PM EST | **Phone:** 1-888-923-4648 | **Fax:** 1-877-705-2282 | **Website:** www.AFINITOR.com

AFINITOR® (everolimus) tablets 2.5mg | 5mg | 7.5mg | 10mg

AfiniTRAC, P.O. Box 1476,
San Bruno, CA 94066

1. PATIENT INFORMATION

Patient Name | Gender ☐ Male ☐ Female

Social Security Number | Date of Birth

Language Preference

Legal Guardian Name (if applicable) | Relationship

Phone # | Alternate Phone #

Best Time to Call ☐ AM ☐ PM | E-mail Address

Address

City | State | ZIP

Patient Prescription Insurance Information

Please attach a copy of the front and back of the patient's insurance card(s), if applicable.

Insurance Name

Policyholder Name

Relationship to Patient | Policyholder DOB

Rx BIN/PCN #

Group # | ID #

Pharmacy Services Phone # (back of card)

Patient Medical Insurance Information

Fill in this section only if information differs from the *Prescription Insurance Information* section above.

Insurance Name

Policyholder Name

Relationship to Patient | Policyholder DOB

Insurance Phone #

Group # | Policy/ID #

Rx BIN #

Preferred Pharmacy Information

Pharmacy Name

Phone # | Fax #

Address

City | State | ZIP

Please see accompanying full Prescribing Information.

2. COMPLETE PRESCRIBER INFORMATION

Prescriber Name | Specialty

Facility Name

Address

City | State | ZIP

Phone # | Fax #

NPI # | Tax ID # | DEA/State License #

Office Contact Name

Office Phone # | Office E-mail

3. READ AND SIGN

PRESCRIBER SIGNATURES

I have read and agree to the Prescriber Consent (section 4) on page 2 of this document. **(REQUIRED)**

X

Prescriber Signature (no stamps) **Date**

I have read and agree to the Prescription Information (section 7) on page 3 of this document. I certify that I am the health care professional who has prescribed AFINITOR® (everolimus) Tablets to the patient identified on this form. I authorize the Novartis Group to transmit prescribing information to a third party(ies) to dispense AFINITOR to this patient. **(REQUIRED)**

X

Prescriber Signature (no stamps) **Date**

I have read and agree to the AFINITOR Free-Trial Support Program (section 8) on page 3 of this document. I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge. **(OPTIONAL)**

X

Prescriber Signature (no stamps) **Date**

I have read and agree to the Patient Assistance Program Consent for Physician (section 5) on page 2 of this document. **(OPTIONAL)**

X

Prescriber Signature (no stamps) **Date**

PATIENT SIGNATURES

I have read and agree to the Patient Authorization (section 6) on page 2 of this document. **(REQUIRED)**

X

Patient or Legal Guardian Signature **Date**

I have read and agree to receive materials, promotions, and offers according to the terms of Patient Marketing Consent (section 9) on page 4 of this document. **(OPTIONAL)**

X

Patient or Legal Guardian Signature **Date**

I have read and agree to the Patient Assistance Program Consent (section 10) on page 4 of this document. **(OPTIONAL)**

X

Patient or Legal Guardian Signature **Date**

4. PHYSICIAN AUTHORIZATION

I certify that I have provided the patient with materials that describe AfiniTRAC and have enrolled the patient in this program at the patient's request and that the patient agrees to be contacted by Program administrators.

5. PATIENT ASSISTANCE PROGRAM CONSENT FOR PHYSICIAN (TO BE SIGNED ONLY IF PATIENT IS APPLYING TO PATIENT ASSISTANCE PROGRAM [PAP])

My signature in Section 3 certifies that the person listed is my patient for whom I have prescribed the drug identified on the third page. I certify that any medications received from Novartis Pharmaceuticals Corporation, its affiliates, business partners and agents (together, the "Novartis Group") in connection with this application will be used only for the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. I acknowledge that I have assisted the patient in enrolling in the Novartis PAP exclusively for purposes of patient care and not in consideration for, expectation of, or actual receipt of remuneration of any sort. I also agree that Novartis has the right to contact the patient directly to confirm receipt of medications, and I understand that Novartis may revise, change, or terminate this program at any time. Finally, to the best of my knowledge, the patient listed above meets Novartis' eligibility criteria for the PAP.

6. PATIENT AUTHORIZATION

I authorize my doctor(s) and their staff, my employer, my caretaker, and my health insurer(s) 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 AFINITOR® (everolimus) Tablets, (ii) coordinate my receipt of and payment for AFINITOR, (iii) facilitate the administration of AFINITOR to me, (iv) provide disease awareness and management programs and materials to me or my caretaker, (v) manage the AFINITOR Patient Support Program, and (vi) conduct market research, quality assurance, and other internal business activities. I authorize the Novartis Group to disclose my Personal Information to any pharmacies, insurance carriers, health care providers (including my doctor(s) and their staff), my caretaker, and other third parties for the purposes described above. I understand that these other parties may report back to the Novartis Group any Personal Information about me that they may create or receive and that the Novartis Group may disclose such Personal Information to my caretaker, to my doctor(s) and their staff and use it for the purposes described above. I authorize the Novartis Group to contact me or my caretaker directly for the purposes described above. I agree to receive AFINITOR Patient Support Program phone calls and mailing materials from the Novartis Group at the number(s) and address provided. I understand that my cell phone carrier's standard rates may apply for calls received at the numbers provided. I understand and agree that my pharmacy, health insurance company, and health care providers may receive remuneration from the Novartis Pharmaceuticals Corporation in exchange for disclosing my Personal Information to Novartis Pharmaceuticals Corporation and/or for providing me with therapy support services subsidized by Novartis Pharmaceuticals Corporation. I understand that once my health information is disclosed it may no longer be protected by federal or state law regarding patient privacy and that neither my doctor(s), nor my employer, nor my health insurer can guarantee that it will not be redisclosed to a third party. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect the commencement, continuation, or quality of my treatment by my doctor(s); however, if I revoke this authorization, I may no longer be eligible to participate in the AFINITOR Patient Support Program. I understand that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier by calling 1·888·923·4648. I also understand that the AFINITOR Patient Support Program may be changed or ended at any time without prior notification and that I may receive a copy of this authorization.

7. PRESCRIPTION INFORMATION

Patient Name: _____

Rx: AFINITOR® (everolimus) Tablets for oral administration
Dosage strength (check one)
☐ **2.5 mg** ☐ **5 mg**
☐ **7.5 mg** ☐ **10 mg**
Other Dosing _____

Dosing Instructions: Take _____ Tablet(s) Once Per Day

Quantity _____ # of Days Supplied _____

Refills Authorized _____ Void After _____ Days

Primary Diagnosis _____ **ICD-9 Code** _____

Secondary Diagnosis (if any) _____ **ICD-9 Code** _____

Rx: AFINITOR DISPERZ™ (everolimus tablets for oral suspension)
Dosage strength (check one)
☐ **2 mg** ☐ **3 mg** ☐ **5 mg**
Administer as oral suspension in water only.
☐ Drink ___ mg once daily. ☐ Other _____

Patient Height _____ Patient Weight _____

BSA _____

Allergies ☐ NKDA or List: _____

Current Therapies/Medications _____

Therapeutic Equivalents
If applicable, list prior patient medications and related information.

Past Therapy _____ Dates of Therapy _____

Justification for Brand Name _____

8. AFINITOR SUPPORT PROGRAMS

Below, please find additional AFINITOR programs that are designed to offer financial support and other assistance, such as the 7-Day Free Trial Program and Prior Authorization.

AFINITOR 7-DAY FREE TRIAL PROGRAM (OPTIONAL)

The AFINITOR 7-Day Free Trial Program provides patients with an introductory supply of AFINITOR. Eligible patients can receive an introductory 7-day supply and continue to receive temporary support for up to 56 days OR until their coverage begins. This program is available to all patients without regard to purchase of AFINITOR or any other product.

Dispensed directly from the AFINITOR® (everolimus) Tablets for oral administration or AFINITOR DISPERZ™ (everolimus tablets for oral suspension) Support Program (at no cost to patient).

DISPENSE: 7-DAY SUPPLY REFILLS: 7

Dispense 1 AFINITOR® (everolimus) Tablets box
☐ **2.5 mg** ☐ **5 mg** ☐ **7.5 mg** ☐ **10 mg**

To be taken _____

Dispense 1 AFINITOR DISPERZ™ box
☐ **2 mg** ☐ **3 mg** ☐ **5 mg**

To be taken _____

Starter product shipping address (check one)
If shipping address is the same as stated on page 1, you do not need to complete again.

☐ **Prescriber Address** ☐ **Patient Address** ☐ **Other Address** (below)

Phone # _____

Alternate Phone # _____

Address _____

City _____ State _____ ZIP _____

NOTE: New York state prescribers must submit a state-approved prescription with this completed form.

Please see accompanying full Prescribing Information for AFINITOR and AFINITOR DISPERZ.

PATIENT ASSISTANCE PROGRAM (PAP) (OPTIONAL)

This step is not required if you are not applying for the patient assistance program. (For patient assistance consideration, please attach proof of income.)

Total number in household (including patient) _____

Number of adults contributing to household income _____

Are you a US resident? ☐ Yes ☐ No
Are you a veteran of the US Armed Forces? ☐ Yes ☐ No
Have you received disability payments from Social Security for more than 24 months? ☐ Yes ☐ No
Do you have an application pending with Medicaid? ☐ Yes ☐ No

Salary/Wages $ _____ Social Security $ _____

Disability $ _____ Pension/Retirement $ _____

Alimony/Child support $ _____ Unemployment/Workman's comp $ _____

Total household gross monthly income $ _____

Total household assets (exclude first home and car) $ _____

PRIOR AUTHORIZATION PROGRAM (OPTIONAL)

1) Is the requested medication:
☐ New ☐ Continuation of therapy ☐ Reauthorization

2) Has this patient had failure/intolerance to any other therapies for this diagnosis? If so, please list. OR please list therapeutic alternatives previously used with start/end dates and outcome:
For additional space, please use back of form.
_____

3) Length of therapy anticipated? _____

4) Is this therapy being used in combination with any other therapies?
☐ Yes ☐ No
If so, please list. _____

9. PATIENT MARKETING CONSENT

I would also like to receive marketing information, offers, and promotions from Novartis Pharmaceuticals Corporation regarding its products, programs, and services. I understand that the Personal Information I supply to Novartis Pharmaceuticals will be shared with and among its business partners to provide me with Novartis-specific products, programs, services, and/or to conduct market research. I understand that Novartis Pharmaceuticals does not permit my Personal Information to be used by any of its business partners for their own separate marketing purposes. I agree to receive phone calls, e-mails, and mailed materials from Novartis Pharmaceuticals at the number(s) and address provided. I understand that my cell phone carrier's standard rates may apply for calls received at the numbers provided. I may cancel my participation at any time by calling 1-888-923-4648 and can find further information about Novartis Pharmaceuticals privacy practices in its privacy policy at www.pharma.us.novartis.com.

10. PATIENT ASSISTANCE PROGRAM CONSENT FOR PATIENT (TO BE SIGNED ONLY IF APPLYING TO PAP)

I give permission for my doctor(s) and their staff to disclose my personal information, including information about my insurance, prescription, medical condition, and health ("Health Information") to the Novartis Patient Assistance Foundation, Inc. (the "Foundation") so that the Foundation can decide if I am eligible for the Novartis Patient Assistance Program ("PAP"); operate the PAP and the Foundation; send me information about PAP and other programs that might help me pay for my medicines; send my information to other programs that might help me pay for my medicines; ask me for financial, insurance, and/or medical information, and share my information as required or permitted by law. I give permission to the Foundation to use information on this Application and any other information I give to the Foundation for these same reasons. I also give the Foundation permission to share my Health Information and other information with people and companies that work with the Foundation: government agencies, including the Centers for Medicare and Medicaid Services; insurance companies, including Medicare Part D plans; my doctor(s) and other people, or institutions who are involved in my health care, such as pharmacies and hospitals; other organizations that might help me pay for my medication. I promise that any information, including financial and insurance information that I provide to the Foundation, is complete and true and unless I have said something different in this application, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or other form of insurance. If my income or health coverage changes, I will call the PAP at 1-800-277-2254. I know that the Foundation may change or end the PAP at any time. I know that if I do not sign this form, I will not be able to participate in the PAP, but this will not affect my ability to get medical care, seek payment for this care, or affect my enrollment or eligibility for insurance. I know that I can cancel this permission at any time by calling the PAP at 1-800-277-2254. If I do, I have the right to receive a copy of this form.

AFINITRAC® TREATMENT | RESOURCES | ACCESS | COMMITMENT

NOVARTIS