GILENYA® (fingolimod) Start Form and Prescriptions **Fax** 1-877-428-5889 **Phone** 1-800-GILENYA (1-800-445-3692)

Please complete all fields indicated to prevent any delays in filling the prescription. Please include copies of both sides of all insurance plan cards.
Attn: New York Prescribers Please submit prescription on original NY state prescription forms.

1. Patient and Insurance Information

Cannot process form without this completed

First Name _____ Last Name _____

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

Home Phone _____ Cell Phone _____

E-mail Address (To make more communications convenient and paperless) _____

Address (For patients in Puerto Rico, please provide physical address) _____

City _____ State _____ ZIP _____

OK to leave a GILENYA message on: ☐ Cell ☐ Home Phone

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Name of Caregiver/Alternate Contact _____

Insurance Name(s) _____

Beneficiary/Cardholder Name(s) _____

Insurance ID Number(s) _____ Group Number(s) _____

Insurance Phone Number(s) _____

Prescription Insurance Name _____

Prescription Insurance ID Number _____ Phone _____

Cannot process form without this completed

X _____ / / _____

Patient/Legal Guardian Signature
I have read and agree to the attached Patient Authorization (page 2).

Date of Signature (MM/DD/YYYY)

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

☐ I have read and agree to receive text messages and calls as explained in the Telephone Consumer Protection Act (TCPA) consent on page 2. (optional)

☐ I have read and agree to the Novartis Patient Assistance Foundation (NPAF) and Fair Credit Reporting Act Authorization on page 2. (optional)

FOR OFFICE USE ONLY

2. Prescriber Information

Cannot process form without this completed

First Name _____ Last Name _____

Address / Site Name _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

State Medical License # _____ NPI # _____

Office Contact Name _____ Office Contact Phone _____

E-mail Address _____

3. Assistance Requested From GILENYA Assessment Network (GAN)*

☐ GILENYA@Home† and/or GILENYA@Medical Facility‡

Blood Tests: ☐ CBC ☐ LFTs and Bilirubin ☐ VZV Antibody Serology

☐ ECG Through the GAN ☐ ECG Through CardioNet in Prescriber Office ☐ ME Screening§

☐ First-Dose Observation (FDO) ☐ Patient Is Cleared for FDO Scheduling

☐ Co-Pay Support Only

* A benefit investigation to determine co-pay support will be completed even if assistance for treatment initiation is not requested.

† Free to eligible commercially insured and uninsured patients. Health care professionals overseeing FDO via GAN will evaluate pre-existing conditions or concomitant medications that may preclude the patients from completing their FDO in a Novartis-sponsored facility.

‡ Medicare is accepted at most GAN medical facilities. There is a cash-pay option for residents of RI. This offer is not valid for medical assessments for which payment may be made in whole or in part under federal or state health programs, including but not limited to Medicare or Medicaid, and for RI residents. This program is subject to termination or modification at any time.

§ Macular Edema screening is available in select areas.

4. Starter Product Rx

Starter product is optional and available at no cost to the patient. It is dispensed directly from the GILENYA *Go Program*®.

☐ Dispense 2 boxes (7 capsules per box) of GILENYA 0.5 mg, 1 capsule taken by mouth once a day and, if needed, additional supplies for a maximum of a 56-day supply.

Alternate Instructions: _____

Starter product shipping address:

☐ Prescriber's Address ☐ Prescriber's FDO Site on File

☐ GILENYA@Home or GILENYA@Medical Facility ☐ Other Address (Provide Below)

New/Other Site Details _____

Address _____ City _____ State _____ ZIP _____ Phone _____

5. Ongoing Rx

Dispense (check one):

☐ 1-month supply followed by 11 refills. Take 0.5 mg by mouth once a day.

☐ 3-month supply followed by 3 refills. Take 0.5 mg by mouth once a day.

Primary diagnosis: ICD-10: G35 or Other: _____

Preferred specialty pharmacy: _____

Alternate instructions: _____

Additional notes:

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 physician who has prescribed GILENYA to the previously identified patient and that I provided the patient with a description of the GILENYA *Go Program*. 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 these prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies.

Cannot process form without this completed

X _____ _____ / / _____

Prescriber Signature (Dispense as Written) (Brand Exchange Permissible) **Date of Signature (MM/DD/YYYY)**

☐ I have read and agree to the Prescriber Authorization for the NPAF on page 2. (if applicable)

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 GILENYA, (ii) coordinate my receipt of and payment for GILENYA, (iii) facilitate my access to GILENYA, (iv) provide me with information about GILENYA, disease awareness, management programs, and educational materials, (v) manage the GILENYA *Go Program*, (vi) provide me with adherence reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with the GILENYA *Go Program*, and (viii) if I choose to apply to programs offered by the NPAF, to administer those programs, to send me information about programs that might help me pay for my medicines, and 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 the GILENYA *Go Program* 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. I also may revoke (withdraw) this authorization with respect to NPAF at any time in the future by calling 1-800-277-2254.

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 the GILENYA *Go Program* 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. 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 GILENYA *Go Program* 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 address(es) provided, and I agree to notify the Novartis Group and/or NPAF promptly if any of my numbers or addresses 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 calls and texts from and on behalf of Novartis Pharmaceuticals Corporation, made with an auto dialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. I agree to the TCPA Terms & Conditions. Number of messages will vary based on your program selections. Message and data rates may apply. Text STOP to opt out and HELP for help.

Co-Pay Assistance Program Terms and Conditions Limitations apply. Up to a $18,000 annual limit. Offer not valid under Medicare, Medicaid, or any other federal or state program. Novartis reserves the right to rescind, revoke, or amend this program without notice. Limitations may apply in MA and CA. See complete Terms & Conditions for details at GILENYA.com.

Novartis Patient Assistance Foundation, Inc. (NPAF) and Fair Credit Reporting Act (FCRA) Authorization I understand that I am providing "written instructions" authorizing NPAF and its vendor, under the FCRA, to obtain information from my credit profile or other information from Experian Health, solely 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 1-800-277-2254. If eligible, I would like to be considered for programs administered by NPAF.

Prescriber Authorization for the Novartis Patient Assistance Foundation, Inc. (NPAF) I certify that any medication received 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.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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