SERVICE REQUEST FORM

FAX: [1-866-318-6975] PHONE: [1-866-EXTAVIA (398-2842)]

EXTAVIA® go program®

STEP 1 Complete Patient and Insurance Information

(please include copies of insurance cards)

Service will be delayed if all fields are not completed

First Name _____ Last Name _____ Suffix _____

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

Address _____

City _____ State ZIP

Home Phone _____ Cell Phone _____

E-mail Address _____

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

Primary Language: ☐ English ☐ Spanish ☐ Other_____

Primary Insurance Name _____

Beneficiary/Cardholder Name _____ ID # _____

Group # _____ Phone _____

Prescription Insurance Name _____

ID # _____ Phone _____

E-mail Address _____

STEP 2 Read & Sign Patient Authorization

I have read and agree to the Patient Authorization on page 2 of this document. ***(Signature required)***

X _____ _____

Patient/Legal Guardian Signature **MM/DD/YYYY**

Please be sure to have your patient read the Patient Authorization section on page 2 carefully, and then sign and date where indicated. Please note that this form will be considered incomplete unless all necessary signatures are present.

☐ **I have read and agree to the Terms and Conditions for Participation in the EXTAVIA Co-Pay Assistance Program on Page 2 of this document.**

STEP 3 Prescriber Requests

Injection Training Support:

☐ Dispense Training Kit

☐ Ship EXTAVIA auto-injector to patient

Dispense 1 box
(15 vials, 30 days of treatment) **EXTAVIA**

Indicate ICD code: _____

To be taken as:

☐ **Maintenance** - 0.25 mg (1 mL) inject every other day subcutaneously

☐ **Titration** - Inject every other day, subcutaneously as follows:

Weeks 1-2: 0.0625 mg (0.25 mL)
Weeks 3-4: 0.125 mg (0.5 mL)
Weeks 5-6: 0.1875 mg (0.75 mL)
Weeks 7+: 0.25 mg (1 mL)

Refill _____ times

STEP 4 Prescriber Information

First Name _____ Last Name _____ Suffix _____

Site Name _____

Address _____

City _____ State ZIP

Phone _____ Fax _____

State Medical License # _____ NPI # _____

Office Contact _____ Office Contact Phone _____

E-mail Address _____

STEP 5 Read & Sign Physician Authorization

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the physician who has prescribed EXTAVIA to the previously identified patient and that I provided the patient with a description of the EXTAVIA *Go Program*. I authorize the EXTAVIA *Go Program* to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

X _____ _____

Prescriber Signature **MM/DD/YYYY**

EXTAVIA® interferon beta-1b FOR SC INJECTION

Please read the following carefully, then sign and date where indicated on page 1.

EXTAVIA *Go Program*

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 (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 EXTAVIA, (ii) coordinate my receipt of, and payment for EXTAVIA, (iii) facilitate my access to EXTAVIA, (iv) provide me with information about EXTAVIA, disease awareness and management programs and educational materials, (v) manage the EXTAVIA *Go Program*, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys and other internal business activities in connection with the EXTAVIA *Go Program*.

I give permission to the Novartis Group to disclose my Personal Information to my HCPs, pharmacies, health insurer(s), caregivers, and other third party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s) and HCPs may receive remuneration (payment) 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.

I understand that once my Personal Information is disclosed it may no longer be protected by federal privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization 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. My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctor(s); however, if I revoke this authorization, I may no longer be eligible to participate in the EXTAVIA *Go Program*. If I revoke this authorization, the Novartis Group will stop using or sharing my information (except as necessary to end my participation in the program) but my revocation will not affect uses and disclosures of my 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 EXTAVIA *Go Program* 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 by mail, e-mail, telephone calls and text messages at the number(s) and address(es) provided on the Service Request Form for all purposes described in this Patient Authorization. I also agree to be contacted by the Novartis Group and on its behalf by telephone calls and text messages made by using an automatic telephone dialing system or prerecorded voice, at the number(s) provided on the Service Request 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 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 Novartis Pharmaceuticals Corporation does 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.

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. Finally, Novartis requires patients to annually re-enroll and re-attest to the program Terms and Conditions. We 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 Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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