EPASS™ Complete Care

EXJADE® Tablets for Oral Suspension (deferasirox)

EPASS™
(EXJADE® PATIENT ASSISTANCE AND SUPPORT SERVICES) PRESCRIPTION AND REIMBURSEMENT APPLICATION
Phone: 1-888-90-EPASS (1-888-903-7277)

*** Please complete each section, sign, and fax both pages ***

PRESCRIBER INFORMATION 1

Prescriber Name: _____

Specialty: _____

State License #: _____ DEA #: _____

National Prescriber Identification (NPI) #: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ ZIP: _____

Office Contact Name: _____

CLINICAL INFORMATION 2

Prior or current Desferal®/deferoxamine patient? ☐ YES ☐ NO

Check all that apply:

☐ Transfusion Protocol ☐ Intermittently Transfused

☐ Prior transfusion history not currently transfused

# of Years on Transfusion: _____ Serum Ferritin Level: _____

Primary Diagnosis: _____

ICD-9 Code: _____

PRESCRIPTION INFORMATION 3

Drug: EXJADE® (deferasirox) # of Days Supplied: _____

# of Refills: _____ Patient Weight (kg): _____

Total Daily Dose: _____ (must be divisible by 125 mg)

Frequency: _____

Other Prescribing Information: _____

PRESCRIBER CONSENT 4

I acknowledge that I have assisted the patient in enrolling in the EPASS System exclusively for the purpose of patient care. I certify that I am prescribing the drug listed above for the patient listed to the right, and I authorize the EPASS System to transmit this prescription form electronically, by facsimile, or by mail to a dispensing pharmacy. I appoint EPASS as my agent to convey on my behalf to the pharmacy of patient's choice the prescription described herein. In addition, if agreed upon with the patient, I understand that the dispensing specialty pharmacy may send the medication to my office to deliver to the patient. I agree that I will not seek reimbursement for any medication provided hereunder from any government program or third party insurer.

Prescriber Signature (no stamps)

Name (print) **Date**

*CA required field for enrollment

PATIENT INFORMATION 5

Patient Name: _____ DOB: _____

Gender: ☐ M ☐ F Language Preference: _____

Phone: _____ Alt. Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Alternate Contact: _____

Relationship: _____ Phone: _____

Best Time to Call: ☐ AM ☐ PM

PRESCRIPTION DRUG INSURANCE INFORMATION 6

Do you have prescription coverage? ☐ YES ☐ NO

If no, you will be contacted to discuss alternate coverage.

If yes, either complete the following section **or submit an enlarged photocopy of the front and back of your Rx card.**

Prescription Insurer Name: _____

Rx Bin #: _____ Rx PCN # (if applicable): _____

Rx Group #: _____ ID #: _____

Name on Card: _____

Pharmacy Services Phone # (back of card): _____

Patient Specialty Pharmacy Preference: ☐ No Preference

☐ Accredo Health Group ☐ BioScrip ☐ US Bioservices

Medical/Secondary Insurer: _____

Policy Holder's Name: _____

Phone: _____ MD's Provider #: _____

Group #: _____ Policy #: _____

HEALTH EDUCATION PROGRAM ENROLLMENT 7

Yes! I agree to enroll in the ***Health Education Program***. This is a *free* disease education program.

The privacy and security of your personal information is important to Novartis. The personal information you supply to us will be shared with and among our business partners, affiliates, and agents to provide you with the information, products, programs, and services and to conduct market research. Your information may be combined with information from other areas of programs in which you participate. The information you supply may be shared with your healthcare provider to assist with monitoring and managing your health. Your information will not be used by any of our business partners, affiliates, and/or agents for their own separate purposes. You have the right to cancel your participation at any time by calling (866) 439-5233. For further information about Novartis privacy practices, please review our privacy policy at www.us.exjade.com.

By providing my information and signing below, I agree to receive requested materials and marketing information from the Health Education Program and related Novartis Pharmaceuticals brands and health issues. I permit Novartis Pharmaceuticals Corporation to use my personal information as described in the above notice and as specified in our privacy policy.

☐ I am a patient/friend/family member ☐ I am a caregiver of a child

Patient or Patient's Representative Signature Required*

If you are a caregiver, please provide the following personal information:

First Name: _____ Last Name: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

PATIENT CONSENT/AUTHORIZATION 8

I have read, understood, and signed the patient consents/authorizations on page 2 of this application form and understand that my physician will be notified of my enrollment and treatment status.

Signature of Patient or Patient's Representative

Name (print) **Date**

(If signed by Representative, explain authority to act for the Patient)

Consent/Authorization to Disclose Health Information

Print Patient Name

I authorize my Doctor and his/her staff to disclose my health information and any other personal information (as noted on page one of this form) to Novartis Pharmaceuticals Corporation, its affiliates, and its agents who have been hired to administer the Novartis EPASS System and/or the Novartis Patient Assistance Program (collectively, "Novartis") for these organizations to use and/or disclose among Novartis my health information to help coordinate my receipt and proper administration of an iron overload medication, which will be prescribed by my Doctor. I also authorize my employer and health insurer to disclose information about my health insurance coverage to Novartis in order to coordinate my receipt of the medication.

Signature of Patient or Patient's Representative Date
(If signed by Representative, explain authority to act for the Patient.)

I also authorize Novartis to disclose information it receives about me to the specialty pharmaceutical company (the "Pharmacy") that will fill my prescription and help manage certain aspects of its administration, and which may invite me to participate in medication management programs and receive educational materials related to iron overload therapy.

I understand that once my health information is disclosed, neither my Doctor, my employer, nor my health insurer can guarantee that it will not be redisclosed to a third party. However, I understand that Novartis will not release my information to any party other than the Pharmacy without first obtaining my (or my authorized representative's) separate written authorization.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that my refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my Doctor.

I understand that this Consent/Authorization will remain in effect for five years from the date of my signature, unless I revoke it earlier by calling the EPASS System's toll-free number (888-903-7277) or providing written notice of revocation to my Doctor. I understand that if I revoke this Authorization I will no longer be able to participate in the EPASS System and receive the iron overload medication.

I also understand that the EPASS System can be changed or ended at any time, without prior notification.

I understand that I have the right to receive a copy of this Authorization.

Signature of Patient or Patient Representative Date
(If signed by Representative, explain authority to act for the Patient.)