MAYZENT® Prescription Start Form

FAX
1-877-750-9068

ENROLL ONLINE
CoverMyMeds.com

QUESTIONS? CALL
1-877-MAYZENT (1-877-629-9368)

MAYZENT®
(siponimod) tablets
0.25 mg • 2 mg

☐ New Patient ☐ Restarting Treatment

1. PATIENT INFORMATION

Cannot process form without this field completed

First Name _____ Last Name _____

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

Address (no PO boxes) _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

E-mail _____

Contact Preferences
☐ OK to leave MAYZENT voicemail

Preferred Language
☐ English ☐ Spanish

Caregiver Information

Name of Caregiver (First & Last) _____ Caregiver Phone _____

Insurance Information
(include a copy of both sides of all cards, including secondary insurance)

Medical Insurance(s)

Cardholder Name(s) _____

Insurance Carrier(s) _____ Phone Number(s) _____

Cardholder ID Number(s) _____ Group Number(s) _____

Prescription Insurance

Cardholder Name _____

Prescription Insurance Carrier _____ Phone Number _____

ID Number _____ Group Number _____

PCN Number _____ BIN Number _____

2. PATIENT AUTHORIZATIONS AND ADDITIONAL CONSENTS

Cannot process form without this field completed

I have read and agree to the Patient Authorization, which includes sharing of genetic information (page 3)

→ X _____ / / _____
Patient/Legal Guardian Signature **Date of Signature** (MM/DD/YYYY)

☐ MAYZENT Co-pay Program: I have read and agree to the Terms and Conditions for participation (please see page 4)

☐ Receiving text messages and calls: I have read and agree to receiving marketing texts and calls as explained in the Telephone Consumer Protection Act (TCPA) Consent (optional, please see page 3)

☐ I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization (optional, please see page 4)

FOR OFFICE USE ONLY

3. PRESCRIBING PHYSICIAN INFORMATION

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First Name _____ Last Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

State Medical License # _____ NPI # _____

Office Contact Name _____ Office Contact Phone _____

E-mail Address _____

4. ASSESSMENT SUPPORT

Assessment assistance requested*†: (check all that apply)

Blood Tests:
- ☐ CBC
- ☐ LFTs (transaminase & bilirubin)
- ☐ VZV antibody serology
- ☐ Genotype CYP2C9‡

Cardiac Evaluation:
- ☐ Electrocardiogram (ECG)

Eye Exam:
- ☐ Macular edema screening‖

OR

No assessment assistance requested and I clear for therapy:
- ☐ The following tests are completed or not required for this patient: CBC, LFTs (transaminase & bilirubin), VZV antibody serology, genotype CYP2C9 (to determine dose),‡ ECG, and a macular edema screening

First Dose Observation (FDO) period: (select one)
- ☐ FDO assistance requested for this patient¶
- ☐ FDO not required for patient¶
- ☐ FDO required for patient¶ and will be performed outside of the support program

Ship treatment initiation product for FDO to:
- ☐ Prescribing office
- ☐ FDO location below:

Health Care Provider _____ Office Contact Phone _____

Address _____

City _____ State _____ ZIP _____

CONTINUED ON THE NEXT PAGE

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5. PRESCRIPTION INFORMATION

A DOSE IS REQUIRED TO INITIATE COVERAGE SUPPORT.
PRODUCT WILL NOT BE DISPENSED UNTIL YOU HAVE CLEARED THE PATIENT FOR THERAPY.

The recommended maintenance dose is 2 mg[#] taken orally once daily. **You will be required to confirm or change the patient's dose before dispense.**

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Patient information:

Name (First & Last) _____

Date of Birth (MM/DD/YYYY) ___/___/___

Primary diagnosis: ICD-10:G35 (select one)

- ☐ Active SPMS
- ☐ CIS/RRMS
- ☐ Other: _____

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Treatment Initiation**

For **2-mg** maintenance dose patients:

☐ Free Starter Pack: for patients who will titrate to a 2-mg maintenance dosage.
Refills: 1 additional Starter Pack

Day 1: 1 x 0.25 mg
Day 2: 1 x 0.25 mg
Day 3: 2 x 0.25 mg
Day 4: 3 x 0.25 mg
Day 5: 5 x 0.25 mg

☐ MAYZENT Free First-Month Supply
2 mg, 1 tablet taken orally once a day.
Dispense 1 bottle (30 tablets/bottle)

For **1-mg** maintenance dose patients:

☐ Dispense 4 bottles of 0.25-mg tablets (28 tablets/bottle). No refills

Day 1: 1 x 0.25 mg
Day 2: 1 x 0.25 mg
Day 3: 2 x 0.25 mg
Day 4: 3 x 0.25 mg
Day 5 and every day after: 4 x 0.25 mg

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Ongoing Prescription

Dispense (check only 1 box):

☐ 2 mg, 1 tablet taken orally once a day.
Dispense 1 bottle (30 tablets/bottle),
then 11 refills, or _____ months supply

☐ 1 mg, 4 x 0.25-mg tablets taken orally once a day.
Dispense 4 bottles (28 tablets/bottle),
then 11 refills, or _____ months supply
1 refill = 4 bottles

Preferred Specialty Pharmacy:

_____
Specialty Pharmacy

Bridge to Commercial Coverage of MAYZENT††:
(optional for commercially insured patients only)

Dispensed directly from Homescripts™ at no cost to the patient (check only 1 box):

☐ 2 mg, 1 tablet taken orally once a day.
Dispense 1 bottle (30 tablets/bottle),
then 11 refills, or _____ months supply

☐ 1 mg, 4 x 0.25-mg tablets taken orally once a day.
Dispense 4 bottles (28 tablets/bottle),
then 11 refills, or _____ months supply
1 refill = 4 bottles

6. SIGNATURE AND PHYSICIAN ATTESTATION

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You must authorize these instructions by signing at the end of this section. We cannot process this form without your signature.

I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the physician who has prescribed MAYZENT to the previously identified patient and I provided the patient with a description of the MAYZENT Support 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. I will not attempt to seek reimbursement for free product provided to me for purposes of performing a first-dose observation. I have read and agree to the Prescriber Authorization for the NPAF on page 4.

→ X _____
Prescriber Signature

___/___/___
Date of Signature (MM/DD/YYYY)

ATTN: New York prescribers, please submit electronic prescription to Homescripts Pharmacy, NPI#1528362076.

*A benefits investigation to determine eligibility for certain support services will be completed even if assistance for treatment-related assessments are not requested.
†Listed services provided via Program may be available for commercially insured and uninsured patients starting MAYZENT. Offer not valid for services (i) performed in RI, (ii) for which payment may be made in whole or in part under federal or state health care programs, including, but not limited to, Medicare or Medicaid, or (iii) where prohibited by law. No purchase required. This Program is subject to termination or modification at any time. For questions regarding covered services, please contact your Alongside Coordinator.
‡An FDA-cleared or -approved test for the detection of CYP2C9 variants to direct the use of siponimod is not currently available.
ǁAn ophthalmic evaluation of the fundus, including the macula, is recommended in all patients before starting treatment.
¶FDO is recommended for patients with certain preexisting cardiac conditions, including sinus bradycardia, first- or second-degree [Mobitz type I] AV block, or a history of myocardial infarction or heart failure.
#For patients with a CYP2C9*1*3 or *2*3 genotype, the recommended maintenance dose of MAYZENT is 1 mg once daily (4 x 0.25 mg). For treatment initiation in these patients, the first month's supply should be used. MAYZENT should not be used in patients with a CYP2C9*3*3 genotype. An FDA-cleared or -approved test for the detection of CYP2C9 variants to direct the use of siponimod is not currently available.
**For all patients prescribed a 2-mg maintenance dose of MAYZENT, a 5-day starter pack and one month of maintenance supply are available at no cost when starting or restarting therapy. To avoid an unintended lapse in therapy, patients insured through federal or state health care programs will receive this free medication after confirmation of insurance coverage for MAYZENT. Patients prescribed a 1-mg maintenance dose with either commercial insurance or without any insurance are eligible for their first month's supply when starting or restarting MAYZENT at no cost. Patients will self-titrate to their 1-mg maintenance dose using their first month's supply. Patients prescribed a 1-mg maintenance dose and whose prescriptions are paid for in whole or in part by a federal or state health care program are not eligible for this offer. No purchase required. Free medication will be dispensed by the MAYZENT Program Pharmacy, Homescripts, to the patient or to the health care provider overseeing the first dose observation, as directed. This offer is not health insurance and may not be submitted for insurance reimbursement. Limitations may apply. Novartis reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.
††Eligible patients must have commercial insurance and a valid prescription for MAYZENT. By participating, patient acknowledges intent to pursue insurance coverage for MAYZENT with their health care provider. Program requires the submission of a request for coverage within 9 months post-Program initiation in order to remain eligible. Patients will receive their maintenance drug supply each month for up to 12 months or until they receive insurance coverage approval, whichever occurs earlier. Program is not available to patients who are uninsured or whose medications are reimbursed in whole or in part by Medicare, Medicaid, TRICARE, or any other federal or state program, or where prohibited by law. Patients may be asked to reverify insurance coverage status during the course of the Program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Other limitations may apply. Novartis reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

FAX BOTH PAGES TO **1-877-750-9068**

Please read the following carefully, then check the box where indicated on the previous pages.

PATIENT AUTHORIZATION. I authorize my healthcare providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment, **genetic information, including the results of genetic testing** and prescription details ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") and the Novartis Patient Assistance Foundation, Inc., and its service providers ("NPAF") so they can provide the following support services (the "Services"):

- Help coordinate insurance coverage for, access to, and receipt of my medication.
- Communicate with me about possible financial assistance, including Novartis copay or NPAF programs, and, if I am enrolled, administer my participation in those programs.
- Communicate with me about my medication and treatment, including reminders, health and lifestyle tips, and product and other related information. Communications may be customized based on Personal Information obtained from my Providers.
- Conduct quality assurance and other internal business activities and ask for feedback related to the Services or my treatment.

In delivering the Services, Novartis and NPAF may share my Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with information collected from other sources and use that information to administer the Services. My pharmacies or other healthcare providers may receive payment from Novartis or NPAF for providing certain Services, such as medication or refill reminders, based on my enrollment or participation. Once I authorize disclosure of my Personal Information, it may no longer be protected by federal health privacy law and applicable state laws.

I understand I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling 1-855-537-4678 or writing to:

PO Box 2971

850 Twin Rivers Dr

Columbus, OH, 43216-9532

OR

Customer Interaction Center

Novartis Pharmaceuticals Corporation, One Health Plaza

East Hanover, NJ 07936-1080

This Authorization will expire 5 years after I sign it, or earlier if required by state law, unless I cancel it sooner. If I cancel it, I may no longer qualify for Services from Novartis or NPAF, but it will not impact my Provider's treatment or my insurance benefits. I also understand that if a Provider is disclosing my Personal Information to Novartis or NPAF on an authorized, ongoing basis, my cancellation will be effective with respect to that Provider as soon as they receive notice of my cancellation. Cancellation will not affect prior uses or disclosures.

Telephone Consumer Protection Act (TCPA) Consent

I consent to receive marketing calls and texts from and on behalf of the Novartis Group and NPAF, 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. Number of messages will vary based on your Program selections. Message and data rates may apply. I understand that I can read the full Novartis Pharmaceuticals Corporation Privacy Policy at **www.usprivacy.novartis.com**. Text STOP to opt out and HELP for help.

PATIENT AUTHORIZATION (cont)

MAYZENT Co-pay Program Terms and Conditions

Limitations apply. Valid only for those with private insurance. The Program includes the Co-Pay Card, Payment Card (if applicable), and Rebate, with a combined annual limit of $18,000. Patient is responsible for any costs once limit is reached in a calendar year. Program not valid (i) under Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program, (ii) where patient is not using insurance coverage at all, or (iii) where the patient's insurance plan reimburses for the entire cost of the drug. The value of this Program is exclusively for the benefit of patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles. Program is not valid where prohibited by law. Patient may not seek reimbursement for the value received from this Program from other parties, including any health insurance program or plan, flexible spending account, or health care savings account. Patient is responsible for complying with any applicable limitations and requirements of their health plan related to the use of the Program. Valid only in the United States and Puerto Rico. This Program is not health insurance. Program may not be combined with any third-party rebate, coupon, or offer. Proof of purchase may be required. Novartis reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

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 the vendor, 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.

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. Furthermore, 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

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0.25 mg • 2 mg

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