Beovu® (brolucizumab-dbll) Injection

Beovu GO™

Enrollment Form

PHONE: 1-888-61-BEOVU (23688) FAX: 1-800-266-6799 www.BEOVUGO.com

*Required field

1. PATIENT INFORMATION

Patient First Name*_____ Patient Last Name*_____

Date of Birth (MM/DD/YYYY)*_____ /_____ /_____ Street Address*_____

City*_____ State*_____ ZIP Code* _____

E-mail _____ Home Phone*_____ Cell Phone _____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

☐ OK to discuss my condition and BEOVU Your Way™ participation with my alternate contact/caregiver:

Alternate Contact/Caregiver Name _____ Relationship to Patient _____

Patient Consents and Authorization

Enrollment into BEOVU Your Way includes a dedicated Care Champion to provide personalized support via mail and e-mail throughout your treatment journey. By checking the box below, you can also receive these educational resources and lifestyle support via call and text.

☐ I agree to receive recurring lifestyle support, tips and more via calls and texts at the phone number provided. I understand calls or texts may be autodialed or pre-recorded and are not a condition of purchase. **(Optional)**

Novartis Patient Assistance Foundation, Inc. (NPAF) provides financial support to eligible uninsured and underinsured patients. Proof of income is required. Checking the box below will allow NPAF to verify your income.

☐ I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization on page 5. **(Optional)**

I have read and agree to the Patient Authorization on pages 3 and 4. By signing, I understand that BEOVU Your Way may contact me regarding educational or other support programs as described in the Patient Authorization.

Signature _____ Date _____

Patient or Legal Guardian Signature* (MM/DD/YYYY)*

2. INSURANCE INFORMATION

(If you include a copy of the patient's insurance card, you do not need to fill out this section. Please include a copy of tertiary insurance.)

☐ Patient has no insurance.

	Primary Insurance	Secondary Insurance
Policy Holder Name (complete **only** if different from name in section 1 above)		
Policy Holder's Date of Birth (complete **only** if different from date of birth in section 1 above)		
Insurance Name*		
Insurance Address		
Plan Name		
Medicare Beneficiary ID		
Policy #*		
Group #*		
BIN (pharmacy benefit only)		
PCN (pharmacy benefit only)		
Insurance Phone #		

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FOR OFFICE USE ONLY

3. SUPPORT REQUESTED FOR THIS PATIENT

Provider: Please indicate support level requested by checking at least ONE of the boxes below.

☐ Benefits Investigation, Prior Authorization Support, and Appeals Support

☐ Commercial Co-pay Support ☐ Novartis Patient Assistance Foundation (NPAF) ☐ BEOVU Your Way™ Patient Support

PLEASE NOTE: Enrollment in BEOVU Your Way includes assignment of a dedicated Care Champion and permission to contact the patient in order to provide product, disease state, and lifestyle support via phone, text, e-mail, or mail based on patient consent and preferences.

Commercial Co-pay Program Terms and Conditions on page 4.

4. PROVIDER INFORMATION

Provider Name (First, Last)*_____ State Lic #_____ Tax ID #_____

Provider NPI #*_____ Site of Service _____

Phone*_____ Fax*_____ Address*_____

City _____ State _____ ZIP Code _____

5. OFFICE CONTACT INFORMATION

Primary Office Contact _____ Phone _____ Fax _____

E-mail _____

6. CLINICAL INFORMATION

Dispense* ☐ **Vial(s) NDC: 0078-0827-61**

Rx: BEOVU® (brolucizumab-dbll) injection **Primary Diagnosis***

Exudative age-related macular degeneration	**Right eye**	**Left eye**	**Bilateral**
Stage unspecified	☐ H35.3210	☐ H35.3220	☐ H35.3230
With inactive scar	☐ H35.3213	☐ H35.3223	☐ H35.3233
With inactive choroidal neovascularization	☐ H35.3212	☐ H35.3222	☐ H35.3232
With active choroidal neovascularization	☐ H35.3211	☐ H35.3221	☐ H35.3231
Other (Please provide diagnosis code)			

Has the patient started BEOVU treatment? ☐ Yes. Anticipated Date of Next Treatment _____

☐ No. Anticipated Date of Treatment _____

Physician Certification

Attestation

☐ 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 BEOVU to the previously identified patient, and that I provided the patient with a description of BEOVU GO™. I agree to the NPAF Authorization on page 5.

I also agree to receive communications, including faxes, related to my patient's enrollment or participation in BEOVU GO.

_____

(MM/DD/YYYY)*

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

Patient Authorization

I give permission for my health care providers (HCPs), pharmacies, service providers, and their contractors ("Health Care Providers"), health insurer(s) and their contractors ("Insurers"), and third-party contractors, to disclose my personal information, including information about my insurance benefits, prescriptions, my medical condition and history, adherence to my treatment, and my general health ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates, business partners, and agents ("Novartis"), and the Novartis Patient Assistance Foundation, Inc. ("NPAF") (collectively, "the Companies") so that the Companies may: (i) help verify or coordinate insurance coverage or otherwise obtain payment for my treatment with BEOVU, (ii) coordinate my receipt of and payment for BEOVU, (iii) facilitate my access to BEOVU, (iv) provide me with information about Novartis products, disease education and management programs, and promotional materials, (v) if I am eligible, coordinate the BEOVU Co-pay Program, including managing and communicating with me about the co-pay support options available to me, (vi) provide me with medication reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with the BEOVU Your Way™ program and other related programs, and (viii) if I am eligible to apply to programs offered by NPAF, administer those programs, send me information about programs that might help me pay for medicines, and coordinate or 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 Companies to disclose my Personal Information to my Health Care Providers, insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above. I also give permission to the Companies to combine or aggregate any information collected from me with information Novartis and NPAF may collect about me from other sources for the purpose of providing or administering Program services.

I understand that some of my pharmacies or other health care providers may receive payment from the Companies depending on my enrollment or participation in therapy support services such as prescription refill reminders. I understand that once my Personal Information is disclosed, it may no longer be protected by federal privacy law and applicable state laws. Even though HIPAA may no longer apply, the Companies will safeguard patient data through reasonable security measures and will use and share it only for the purposes specified in this Authorization.

I understand that I may refuse to sign this Authorization. I also may revoke (cancel) or get a copy of this Authorization at any time by calling 1-888-61-BEOVU (23688) or by writing to BEOVU Program, PO Box 221706, Charlotte, NC 28222. If I cancel my consent, I will no longer qualify for the services described. I also understand that if a Health Care Provider or Insurer is disclosing my Personal Information to the Companies on an authorized, ongoing basis, my cancellation with the Companies will be effective with respect to any such Health Care Provider or Insurer as soon as they receive notice of my cancellation.

My refusal or future revocation will not affect my medical treatment or insurance benefits; however, if I revoke this Authorization, I may no longer be able to participate in the BEOVU Your Way support program and related programs. If I revoke this Authorization, the Companies 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 Personal Information previously disclosed in reliance upon this Authorization. I understand

that this Authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier. I also understand that the BEOVU Your Way™ program may change or end at any time without prior notification. I understand that I am entitled to receive a copy of this Patient Authorization.

I agree to be contacted by mail, e-mail, telephone calls, and text messages at the numbers and addresses provided on this Form for all purposes described in this Patient Authorization. I also agree to be contacted by the Companies and others on its behalf by telephone calls and text messages made by or using automatic telephone dialing machines or artificial or prerecorded 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 Companies 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 the Companies 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.

http://www.pharma.us.novartis.com

Commercial Co-pay Support Program Terms and Conditions

Limitations apply. Valid only for those with private insurance. The Program may include the Co-pay Card, Payment Card (if applicable), and Rebate, with a combined annual limit of $12,000. For patients covered under the medical benefit, the rebate for the patient's out-of-pocket costs will be assigned directly to the provider, unless the patient requests direct reimbursement. 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, (iii) where the patient's insurance plan reimburses for the entire cost of the drug, or (iv) where product is not covered by patient's insurance. 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 Novartis Patient Assistance Foundation, Inc. (NPAF) and its vendors, 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.

Novartis Patient Assistance Foundation (NPAF) Authorization FOR PHYSICIAN

I certify that this 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 the drug identified above to the previously identified patient. 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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