Cosentyx® (secukinumab)

SINKS PHARMACY- Service Request Form and Prescriptions

FAX: 888-850-4018 ; *PHONE: 844-422-6400*

Please complete all fields to prevent any delays.
Please include copies of both sides of primary and secondary insurance card(s).

TO BE COMPLETED BY PATIENT

PATIENT INFORMATION

Patient's Last Name | First | Middle

Birth Date | Sex: ☐ M ☐ F

Street Address

City | State | Zip Code

Home Phone | Cell Phone

E-mail

Contact me by: ☐ Cell Phone ☐ Home Phone ☐ E-mail ☐ Text

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

Preferred Language: ☐ English ☐ Spanish

OKAY TO LEAVE MESSAGE? ☐ YES ☐ NO

PARTICIPATION IN CO-PAY ASSISTANCE PROGRAM

☐ I have read and agree to the Terms and Conditions for participation in the COSENTYX® Co-pay Assistance Program on page 3.

INSURANCE INFORMATION

Primary Insurance Name

Beneficiary/Cardholder Name

Primary Insurance ID # | Group #

Primary Insurance Phone

Prescription Insurance Name

Prescription Insurance ID # | Phone

Group # | BIN # | PCN #

☐ I have secondary insurance.

PATIENT AUTHORIZATION

I have read and agree to the Patient Authorization on pages 2 & 3.

Patient/Legal Guardian Signature | Date

TO BE COMPLETED BY PRESCRIBER

PHYSICIAN INFORMATION

First Name | Last Name

Office Contact Number | Contact Name

Site/Institution Name

Office Fax Number | Tax ID #

Office E-mail | NPI #

Address

City | State | Zip Code

SUPPORT REQUESTED FOR THIS PATIENT

Physician: Please indicate support level requested by checking ONE of the following 3 boxes:

☐ **FULL Program Support** requested (eg, benefits investigation, support for prior authorizations/appeals, Patient Services Liaison, co-pay assistance)

☐ CO-PAY ASSISTANCE ONLY

☐ BENEFITS INVESTIGATION ONLY

PLEASE NOTE: IF NONE OF THE 3 BOXES ABOVE IS CHECKED, YOU WILL BE DEEMED TO HAVE SELECTED FULL PROGRAM SUPPORT.

☐ I also request **supplemental home injection training** for this patient.

CLINICAL INFORMATION

TREATMENT HISTORY:

☐ To my knowledge, the patient has not previously been treated with a biologic for the diagnosed condition.

If patient has been treated with a biologic, please provide information below.

Does this patient have a contraindication, intolerance, or allergy to Enbrel®, Humira®, Remicade®, Stelara®, or other biologic treatment? ☐ NO ☐ YES _____

Does this patient have documented failure of adequate trial on Enbrel®, Humira®, Remicade®, Stelara®, or other biologic treatment? ☐ NO ☐ YES _____

If YES, please indicate which drug(s) and date(s) of usage.

Enbrel® From: _____ To: _____ Humira® From: _____ To: _____

Remicade® From: _____ To: _____ Stelara® From: _____ To: _____

Other From: _____ To: _____ Other From: _____ To: _____

COSENTYX PRESCRIPTION INFORMATION

New York prescribers, please submit prescription on an original NY State prescription blank. The physician is to comply with their state-specific form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

Indicate ICD-10 Code(s):

INITIATE PROGRAM FREE MEDICATION PRESCRIPTION (optional, for use by Program Specialty Pharmacy only)

Initiate Program (no cost to patient): Commercially insured patients who are experiencing an insurance coverage delay are eligible for free medication while awaiting coverage. Eligibility requirements and limitations apply. **Patients receiving benefits under Medicare, Medicaid, or any other federal or state program (eg, Tricare) are not eligible for this offer.** Participation is not a guarantee of availability of insurance coverage or alternative financial assistance programs. Offer is not contingent upon purchase requirements of any kind. Enrollment expires 12/31/16.

Initial Weekly Dosing (where appropriate) – Weeks 0, 1, 2, 3, and 4, then once every 4 weeks.

☐ Inject 300-mg dose subcutaneously once weekly for 5 weeks. Each 300-mg dose is given as 2 injections of 150 mg.

☐ Inject 150-mg dose subcutaneously once weekly for 5 weeks.

☐ Sensoready® Pen ☐ Prefilled Syringe

Monthly Dosing – Once every 4 weeks.

☐ Inject 300-mg dose subcutaneously every 4 weeks. Each 300-mg dose is given as 2 injections of 150 mg.

☐ Inject 150-mg dose subcutaneously every 4 weeks.

☐ Sensoready® Pen ☐ Prefilled Syringe Quantity: ☐ 1 Month # of Refills: _____

NETWORK PHARMACY PRESCRIPTION (required)

Preferred Specialty Pharmacy: SINKS PHARMACY

Initial Weekly Dosing (where appropriate) – Weeks 0, 1, 2, 3, and 4, then once every 4 weeks.

☐ Inject 300-mg dose subcutaneously once weekly for 5 weeks. Each 300-mg dose is given as 2 injections of 150 mg.

☐ Inject 150-mg dose subcutaneously once weekly for 5 weeks.

☐ Sensoready® Pen ☐ Prefilled Syringe

Monthly Dosing – Once every 4 weeks.

☐ Inject 300-mg dose subcutaneously every 4 weeks. Each 300-mg dose is given as 2 injections of 150 mg.

☐ Inject 150-mg dose subcutaneously every 4 weeks.

☐ Sensoready® Pen ☐ Prefilled Syringe Quantity: ☐ 1 Month # of Refills: _____

SHIPPING PREFERENCES

First Dose: ☐ Physician Address ☐ Patient Address

Follow-Up Doses: ☐ Physician Address ☐ Patient Address

Co-pay Information: FOR PHARMACY USE ONLY

BIN: _____ Member ID: _____

PCN: _____ Rx Group #: _____

Special Requests:

PHYSICIAN CERTIFICATION

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 COSENTYX to the previously identified patient and that I provided the patient with a description of the COSENTYX Connect Personal Support Program. I authorize the COSENTYX Connect Personal Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

Physician Signature (No Stamp Allowed) | Date

PHYSICIAN CERTIFICATION

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 COSENTYX to the previously identified patient and that I provided the patient with a description of the COSENTYX Connect Personal Support Program. I authorize the COSENTYX Connect Personal Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

Physician Signature (No Stamp Allowed) | Date

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

Patient Authorization

I give permission for my healthcare providers, my pharmacies, and my health insurer(s) 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 COSENTYX, (ii) coordinate my receipt of, and payment for COSENTYX, (iii) facilitate my access to COSENTYX, (iv) provide me with information about COSENTYX, disease awareness and management programs, and educational materials, (v) manage the COSENTYX Connect Personal Support Program, (vi) provide me with adherence reminders and support, and (vii) conduct quality assurance, surveys, and other internal business activities in connection with the COSENTYX Support Program.

I give permission to the Novartis Group to disclose my Personal Information to any pharmacies, my health insurer(s), healthcare providers, my caregivers, and other third parties for the purposes described above. I give permission to the Novartis Group to contact me directly for the purposes described above.

I understand that my pharmacy, health insurer(s), and healthcare providers may receive remuneration (payment) from 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 COSENTYX Connect Personal Support 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.

(continued on next page)

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 COSENTYX Connect Personal Support Program may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

My Contact Information

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 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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