ILARIS® Patient Authorization for ILARIS Co-Pay Program

ILARIS (canakinumab) 150 mg subcutaneous injection

Fax: 1-631-822-2893 **Co-Pay Program Portal:** Ilaris.opushealth.com

* = REQUIRED FIELDS

PATIENT INFORMATION – FORM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

* Name: _____ * Date of Birth: _____
First Name Middle Initial Last Name

* ZIP: _____ Email (recommended to enroll in co-pay support): _____

PATIENT AUTHORIZATION AND ADDITIONAL CONSENTS

I have read and agree to the Patient Authorization on page 2.

_____ ____/____/_____
Patient/Authorized Representative Date of Signature MM/DD/YYYY

ILARIS Co-Pay Program

☐ I have read and agree to the ILARIS Co-Pay Program Terms and Conditions below. I direct the ILARIS Co-Pay Program to make co-pay benefit payments on my behalf directly to my health care providers for qualifying claims.

* 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 $36,000. 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, (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.

For questions, please call: **1-866-972-8315**

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Patient Authorization. I authorize my health care providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment, 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 co-pay 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 health care 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 1-844-267-3689 or writing to:

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.

I agree for myself and certify (if applicable) that my caregiver agrees to receive nonmarketing calls and texts from Novartis or NPAF, including through an autodialer or prerecorded voice, at the number(s) provided.

Please visit the Novartis website: https://www.novartis.us.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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