Novartis
Patient Support™

Guide to completing the Start Form

Novartis Patient Support provides comprehensive resources designed to help your patients start, stay, and save on SCEMBLIX.

Not an actual patient.

For questions or support, reach out to your dedicated Associate Director of Access and Reimbursement (ADAR) or contact Novartis Patient Support.

Phone: 866-433-8000

Fax: 800-368-5564

Online: www.scemblixhcp.com

SCEMBLIX®
(asciminib) 20 mg, 40 mg tablets

Novartis
Patient Support

Your patients are our top priority

Novartis Patient Support provides your practice with comprehensive resources to help your patients start, stay, and save on SCEMBLIX.

We'll help you get your patients started and guide them along the way with:

- Dedicated assistance with insurance and reimbursement
- Personalized support for your patients on therapy
- Single point of contact for you and your patients

Our offerings include:

Insurance Support

We help to minimize the hassle of navigating insurance and reimbursement barriers.

Financial Support

We connect and deliver your patients to relevant savings support.

Ongoing Support

We provide resources and ongoing, personalized support to help your patients along their treatment journey.

Questions?

Call Novartis Patient Support at **866-433-8000**,
Monday-Friday from 8:00 AM-8:00 PM ET, excluding holidays.
Visit **www.scemblixhcp.com** for more information.

The information herein is provided for educational purposes only. Novartis cannot guarantee health plan or reimbursement. Coverage and reimbursement may vary significantly by health plan, patient, and setting of care. It is the sole responsibility of the health care provider to select the proper codes and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient.

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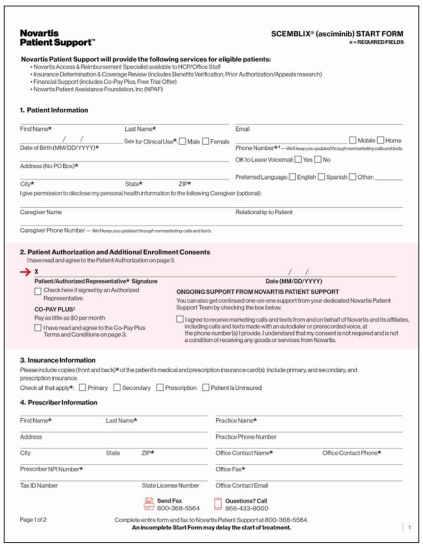
Getting patients started

Novartis Patient Support will work with your practice to help your patient start on SCEMBLIX. Begin the process by completing the Start Form. We have outlined the key information below to help ensure a smoother process for your office and your patient.

Page 1



Novartis Patient Support™

SCEMBLIX® (asciminib) START FORM

* = REQUIRED FIELDS

Novartis Patient Support will provide the following services for eligible patients:

- Novartis Access & Reimbursement Specialist available to HCP/Office Staff
- Insurance Determination & Coverage Review (includes Benefits Verification, Prior Authorization/Appeals research)
- Financial Support (includes Co-Pay Plus, Free Trial Offer)
- Novartis Patient Assistance Foundation, Inc (NPAF)

1. Patient Information

First Name* Last Name* Email

Date of Birth (MM/DD/YYYY)* Sex for Clinical Use* ☐ Male ☐ Female Phone Number* * — We'll keep you updated through non-marketing calls and texts ☐ Mobile ☐ Home

Address (No PO Box)* OK to Leave Voicemail ☐ Yes ☐ No

City* State* ZIP* Preferred Language ☐ English ☐ Spanish ☐ Other:

I give permission to disclose my personal health information to the following Caregiver (optional):

Caregiver Name Relationship to Patient

Caregiver Phone Number * — We'll keep you updated through non-marketing calls and texts

2. Patient Authorization and Additional Enrollment Consents

I have read and agree to the Patient Authorization on page 3.

X

Patient/Authorized Representative* Signature Date (MM/DD/YYYY)

☐ Check here if signed by an Authorized Representative.

CO-PAY PLUS†

Pay as little as $0 per month

☐ I have read and agree to the Co-Pay Plus Terms and Conditions on page 3.

ONGOING SUPPORT FROM NOVARTIS PATIENT SUPPORT

You can also get continued one-on-one support from your dedicated Novartis Patient Support Team by checking the box below.

☐ I agree to receive marketing calls and texts from and on behalf of Novartis and its affiliates, including calls and texts made with an autodialer or prerecorded voice, at the phone number(s) I provide. I understand that my consent is not required and is not a condition of receiving any goods or services from Novartis.

3. Insurance Information

Please include copies (front and back)* of the patient's medical and prescription insurance card(s). Include primary, and secondary, and prescription insurance.

Check all that apply*: ☐ Primary ☐ Secondary ☐ Prescription ☐ Patient is Uninsured

4. Prescriber Information

First Name* Last Name* Practice Name*

Address Practice Phone Number

City State ZIP* Office Contact Name* Office Contact Phone*

Prescriber NPI Number* Office Fax*

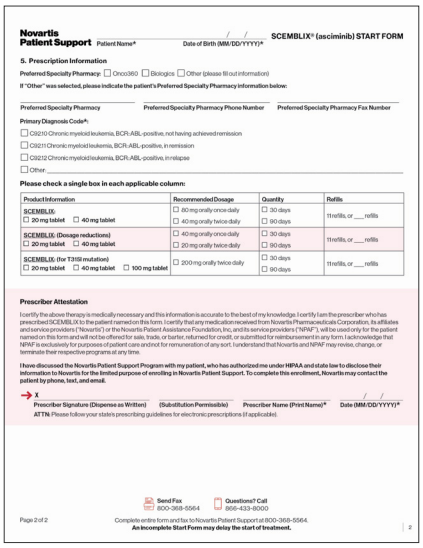
Tax ID Number State License Number Office Contact Email

Send Fax 800-368-5564 Questions? Call 866-633-8000

Page 1 of 2 Complete entire form and fax to Novartis Patient Support at 800-368-5564.

An incomplete Start Form may delay the start of treatment.

Page 2



Novartis Patient Support Patient Name* Date of Birth (MM/DD/YYYY)* SCEMBLIX® (asciminib) START FORM

5. Prescription Information

Preferred Specialty Pharmacy: ☐ Onco360 ☐ Biologics ☐ Other (please fill out information)

If "Other" was selected, please indicate the patient's Preferred Specialty Pharmacy information below:

Preferred Specialty Pharmacy Preferred Specialty Pharmacy Phone Number Preferred Specialty Pharmacy Fax Number

Primary Diagnosis Code*:

☐ C9210 Chronic myeloid leukemia, BCR-ABL-positive, not having achieved remission

☐ C9211 Chronic myeloid leukemia, BCR-ABL-positive, in remission

☐ C9212 Chronic myeloid leukemia, BCR-ABL-positive, in relapse

☐ Other:

Please check a single box in each applicable column:

Product Information	Recommended Dosage	Quantity	Refills
SCEMBLIX: ☐ 20 mg tablet ☐ 40 mg tablet	☐ 80 mg orally once daily ☐ 40 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX: (Dosage reductions) ☐ 20 mg tablet ☐ 40 mg tablet	☐ 40 mg orally once daily ☐ 20 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills
SCEMBLIX: (for T315I mutation) ☐ 20 mg tablet ☐ 40 mg tablet ☐ 100 mg tablet	☐ 200 mg orally twice daily	☐ 30 days ☐ 90 days	11 refills, or ___ refills

Prescriber Attestation

I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the prescriber who has prescribed SCEMBLIX to the patient named on this form. I certify that any medication received from Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") or the Novartis Patient Assistance Foundation, Inc, and its service providers ("NPAF"), will be used only for the patient named on this form and will not be offered for sale, trade, or barter, returned for credit, or submitted for reimbursement in any form. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Novartis and NPAF may revise, change, or terminate their respective programs at any time.

I have discussed the Novartis Patient Support Program with my patient, who has authorized me under HIPAA and state law to disclose their information to Novartis for the limited purpose of enrolling in Novartis Patient Support. To complete this enrollment, Novartis may contact the patient by phone, text, and email.

X

Prescriber Signature (Dispense as Written) (Substitution Permissible) Prescriber Name (Print Name)* Date (MM/DD/YYYY)*

ATTN: Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).

Send Fax 800-368-5564 Questions? Call 866-633-8000

Page 2 of 2 Complete entire form and fax to Novartis Patient Support at 800-368-5564.

An incomplete Start Form may delay the start of treatment.

- **Sections 1-3:** are to be filled out by the patient or their authorized representative
  - Obtain patient and/or authorized representative consent by signature
  - Ensure your privately insured patient checks the appropriate box in section 2 to sign up for Novartis Patient Support Co-Pay Plus
  - Include front and back copies of patient's medical and prescription insurance cards to allow us to verify all of their benefits
- **Sections 4-5:** are to be filled out by the prescriber
  - It is important to review and capture the appropriate diagnosis code prior to initiating therapy
  - Indicate your patient's preferred specialty pharmacy by checking the appropriate box in section 5 and providing their specialty pharmacy information in the space provided
  - Be sure to choose the appropriate product and dose when filling out the table in section 5
  - Please don't forget to sign and date the prescriber attestation
- An incomplete Start Form may delay the start of treatment

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Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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