Complete entire form and fax all 4 pages to Novartis Patient Support at 1-855-951-4363, OR upload completed form at www.zolgensma-enrollment.com or www.itvisma-enrollment.com. Questions? Contact 1-855-441-4363.

Novartis Patient Support™

ZOLGENSMA® (onasemnogene abeparvovec-xioi)
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START FORM

* = REQUIRED

Please select product:

* ☐ **ZOLGENSMA suspension, for intravenous infusion** ☐ **ITVISMA suspension, for intrathecal injection**

All enrollments into Novartis Patient Support will receive local Account Management Support.

1 (OFFICE USE ONLY) Please indicate your office's preferred level of engagement from Novartis Patient Support

☐ **Access and Reimbursement Support**
- Check insurance coverage including nonemergency travel and prior authorization and appeals support

☐ **Laboratory Testing Support**
- Receipt of laboratory results through testing programs sponsored by Novartis to support case management

☐ **Copay Support***
- Enrollment in the CopayAssist™ Program
- **Patient/Caregiver must agree to and check the Copay Support box in Section 4 on page 2**

☐ **Patient/Caregiver Support Calls†**
- Dedicated phone support to help patients/caregivers navigate the process before and after treatment
- **Patient/Caregiver must opt into support calls by checking the Patient/Caregiver Support Calls box in Section 4 on page 2**

☐ **(ITVISMA only) In-Home Blood Draw for Posttreatment Monitoring‡**
- By checking this box, I am selecting this service and certify that I have assessed that my patient requires this support

☐ **All** of the optional services listed above available for the selected product

2 Patient and Parent/Legal Representative Information

* Patient Name (First Name and Last Name) _____
* Date of Birth (MM/DD/YYYY) _____
* Sex for Clinical Use: ☐ Male ☐ Female

* Parent/Legal Representative Name _____
* Phone Number _____ ☐ Mobile ☐ Home
OK to Leave Voicemail: ☐ Yes ☐ No
We'll keep the Parent/Legal Representative informed through nonmarketing calls and texts.†

* Patient Address _____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

* City _____ * State _____ * ZIP _____ Email _____

3 Additional Caregiver Information for Patient/Caregiver Support Calls (optional)

I give permission to disclose my/the patient's personal health information to the following additional caregiver(s) in case the Parent/Legal Representative is unavailable:

Additional Caregiver Name _____ Relationship to Patient _____ Caregiver Phone Number _____ ☐ Mobile ☐ Home
We'll keep the Caregiver informed through nonmarketing calls and texts.†

Additional Caregiver Name _____ Relationship to Patient _____ Caregiver Phone Number _____ ☐ Mobile ☐ Home
We'll keep the Caregiver informed through nonmarketing calls and texts.†

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4 Patient Authorization and Additional Enrollment Consents

☐ **I have read and agree to the Patient Authorization on page 4.**

* **Print Patient or Parent/Legal Representative Name (First Name and Last Name)** * **Date (MM/DD/YYYY)**

X

* **Patient or Parent/Legal Representative Signature** * **Date (MM/DD/YYYY)**

To receive the support described below, the boxes in Section 1 must be checked

COPAY SUPPORT*

☐ I have read and agree to the CopayAssist™ Terms and Conditions on page 4 of this resource.

PATIENT/CAREGIVER SUPPORT CALLS†

☐ I'd like to sign up for access to ongoing support. I'll get tips, resources, and reminders from Novartis Patient Support at the mobile phone number(s) I gave on page 1.

By checking this box, I agree to receive recurring marketing calls and texts from and on behalf of Novartis Pharmaceuticals Corporation. These calls and texts may be automatic or recorded in advance. The number of calls and message frequency varies. My consent is not a condition of getting any goods or services from Novartis. I can opt out of the program at any time by calling 1-855-441-4363.

(ITVISMA ONLY) IN-HOME BLOOD DRAW FOR POSTTREATMENT MONITORING‡

☐ I'd like to sign up for in-home blood draw for posttreatment monitoring.

5 Insurance Information **Please include a copy (front and back) of the patient's insurance card(s) and/or complete the section below.**

Check all that apply: ☐ Patient is the policyholder ☐ Patient is uninsured ☐ Image(s) of insurance card(s) included

* **Primary Medical Insurance** ☐ Private ☐ Medicaid ☐ Medicare ☐ Other: _____

* Insurance Provider * Phone Number

* Policyholder Name * Date of Birth (MM/DD/YYYY) * Policyholder's Relationship to Patient

* Policy ID Number * Group Number

Secondary Medical Insurance ☐ Private ☐ Medicaid ☐ Medicare ☐ Other: _____

Insurance Provider Phone Number

Policyholder Name Date of Birth (MM/DD/YYYY) Policyholder's Relationship to Patient

Policy ID Number Group Number

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6a Treating Prescriber Information

* Treating Prescriber Name
* Treating Prescriber Email
* Treating Prescriber National Provider Identifier (NPI) Number
* Treating Prescriber Provider Transaction Access Number (PTAN)
* Treating Prescriber Address
* City
* State
* ZIP
* Institution Name
* Office Contact Name
* Office Contact Phone Number
* Fax Number
* Institution Address
* City
* State
* ZIP

6b Referring Prescriber Information

Referring Prescriber Name | Referring Prescriber NPI Number | Referring Prescriber PTAN | Referring Prescriber Email

Referring Prescriber Address | City | State | ZIP

Institution Name | Office Contact Name | Office Contact Phone Number | Fax Number

Institution Address | City | State | ZIP

7 Clinical Information

Estimated Treatment Date (MM/DD/YYYY): _____

* Patient Current Spinal Muscular Atrophy (SMA) Treatment (Medication): _____ ☐ Treatment-Naive

(For ZOLGENSMA only)
Most Recent Patient Weight: _____ (kg)

(For ZOLGENSMA only)
Date of Most Recent Patient Weight (MM/DD/YYYY): _____

Patient Age (Months): _____

* **Primary Diagnosis ICD-10-CM Code**

☐ G12.0 – Infantile SMA type 1 (Werdnig-Hoffman)
☐ G12.8 – Other specified SMAs and related syndromes
☐ G12.25 – Progressive SMA
☐ G12.1 – Other inherited SMA
☐ G12.9 – SMA, unspecified

* **Product Acquisition** ☐ Buy and Bill | Specialty Pharmacy ☐ Accredo ☑ Orsini ☐ Axium/Farmacia Doral (Puerto Rico only) | ☐ Undecided

8 Treating 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 provider who has prescribed ZOLGENSMA or ITVISMA 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 Novartis Patient Support 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 _____

* **Treating Prescriber Signature**
* **Treating Prescriber Name (Print Name)**
* **Date (MM/DD/YYYY)**

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Patient Authorization. I authorize my/patient's health care providers, including testing laboratories, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my/patient's insurance benefits, medical condition, treatment, genetic information, including the results of genetic testing and prescription details, and financial information needed to determine financial assistance eligibility ("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 Services:

- Communicate with the patient's Providers about treatment and payment for treatment;
- Check if the patient is eligible for financial assistance provided by NPAF, and administer the patient's participation in NPAF if they are enrolled;
- Help coordinate insurance coverage for, access to, and receipt of medication, if that service is selected above;
- Communicate with Providers about lab test results, if that service is selected above;
- Administer the ZOLGENSMA or ITVISMA CopayAssist™ Program if that service is selected above;
- Administer Caregiver Support Calls, if that service is selected above;
- 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/patient's Personal Information with each other and with my/patient's Providers. They may combine information collected from me/patient 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 based on enrollment or participation. Once I authorize disclosure of my/patient's 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 medication or insurance coverage for me/the patient, that I have a right to a copy, and can cancel this Authorization at any time by calling 1-855-441-4363 or by writing to:

UBC on behalf of Novartis Pharmaceuticals Corporation, 600 Emerson Road, Suite 300, Creve Coeur, MO 63141

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

*__Limitations apply.__ Valid only for those with private insurance. The Program includes the CopayAssist™ Program Plus offer, Plus Card (if applicable), and Rebate, with a combined annual limit up to $20,000. 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 copayments, 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.

†Novartis Patient Support may call and text you at the numbers provided for nonmarketing purposes (eg, to help you access and start on ZOLGENSMA or ITVISMA. Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 1-855-441-4363.

‡__Limitations apply.__ Please contact Novartis Patient Support at 1-855-441-4363 for more information.

Please see full Novartis Pharmaceuticals Corporation Privacy Policy and the Mobile Terms of Use.

Do Not Fax Patient Medical Records.

NOVARTIS

zolgensma® (onasemnogene abeparvovec-xioi) suspension for intravenous infusion

itvisma® (onasemnogene abeparvovec-brve) suspension for intrathecal injection

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080