SERVICE REQUEST FORM

FAX: 1-866-318-6975 PHONE: 1-866-EXTAVIA (398-2842)

EXTAVIA® go program™

Please read the following carefully, then sign and date the corresponding, indicated sections on the pages below.

EXTAVIA *Go Program*

A → Patient Authorization

I authorize my doctor(s) and their staff, my employer, 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 obtain payment for my treatment with EXTAVIA, (ii) coordinate my receipt of, and payment for EXTAVIA, (iii) manage the EXTAVIA *Go Program*, and (iv) conduct market research, quality assurance, and other internal business activities. I agree to receive EXTAVIA *Go Program* phone calls, text messages, and materials from the Novartis Group at the number(s) and address provided. I understand that my cell phone carrier's standard rates may apply for calls or text messages received at the numbers provided.

I authorize the Novartis Group to disclose my Personal Information to any insurance carriers, pharmacies, health care providers (including my doctor(s) and their staff), and other third parties for the purposes described above. I understand that these other parties may report back to the Novartis Group any Personal Information about me that they may create or receive and that the Novartis Group may disclose such Personal Information to my doctor(s) and their staff. I authorize the Novartis Group to contact me directly for the purposes described above. I understand that once my health information is disclosed it may no longer be protected by federal or state law regarding patient privacy and that neither my doctor(s), my employer, nor my health insurer can guarantee that it will not be re-disclosed to a third party. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect the commencement, continuation, or quality of my treatment by my doctor(s). However, I understand that if I revoke this authorization, I may no longer be eligible to participate in the Program. I understand that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier by calling 1-866-EXTAVIA (398-2842). I also understand that the Program may be changed or ended at any time without prior notice. I understand that I may receive a copy of this authorization.

B → Patient Marketing Consent

Yes, I would like to receive marketing information, offers, and promotions from Novartis Pharmaceuticals Corporation regarding its products, programs, and services, and I also agree that I may be contacted for my opinions regarding such products, programs, and services. I understand that the Personal Information I supply to Novartis Pharmaceuticals will be shared with and among its business partners to provide me with products, programs, and services to conduct market research. I understand that Novartis Pharmaceuticals will not permit my Personal Information to be used by any of its business partners for their own separate marketing purposes. My consent will remain valid until I revoke it by calling 1-866-EXTAVIA (398-2842) or writing to the EXTAVIA *Go Program*. I can find further information about Novartis Pharmaceuticals privacy practices in its privacy policy at www.pharma.us.novartis.com. By signing below, I agree that Novartis Pharmaceuticals may use and disclose my Personal Information to deliver marketing information, offers, and promotions and to contact me for my opinions.

www.EXTAVIA.com

NOVARTIS
Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

Printed in USA 7/12 EXD-1168800

EXTAVIA® interferon beta-1b FOR SC INJECTION

SERVICE REQUEST FORM
FAX: 1-866-318-6975 PHONE: 1-866-EXTAVIA (398-2842)
EXTAVIA® go program™

STEP 1 | Complete Patient and Insurance Information

(please include copies of insurance cards)

Service will be delayed if all fields are not completed

First Name _____ Last Name _____ Suffix _____

Sex ☐ M ☐ F Date of Birth: _____ (MM/DD/ YYYY)

Address _____

City _____ State _____ ZIP _____

Home Phone _____ ☐ Preferred ☐ OK to leave message?

Cell Phone _____ ☐ Preferred ☐ OK to leave message?

Primary Insurance Name _____

Beneficiary/Cardholder Name _____ ID # _____

Group # _____ Phone _____

Prescription Insurance Name _____

Group # _____ Phone _____

Email Address _____

STEP 2 | Prescriber Information

First Name _____ Last Name _____ Suffix _____

Site Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

State Medical License # _____ NPI # _____

Office Contact _____ Office Contact Phone _____

Email Address _____

STEP 3 | 30-day Supply Rx Information

Dispense 1 box
(15 vials, 30 days of treatment) **EXTAVIA**

Indicate ICD-9 code: _____

To be taken as:

☐ **Maintenance** - 0.25 mg (1 mL) inject every other day subcutaneously

☐ **Titration** - Inject every other day, subcutaneously as follows:

Weeks 1-2: 0.0625 mg (0.25 mL)
Weeks 3-4: 0.125 mg (0.5 mL)
Weeks 5-6: 0.1875 mg (0.75 mL)
Weeks 7+: 0.25 mg (1 mL)

Refill _____ times

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.

X _____ _____
Prescriber Signature **MM/DD/YYYY**

Injection Training Support:

☐ Dispense Training Kit
☐ Ship EXTAVIA Auto-Injector II to patient

EXTAVIA Nurse Training *(optional)*:

☐ Yes, I would like a skilled nurse to provide EXTAVIA subcutaneous administration and injection device training
☐ No, a nurse visit is not required

STEP 4 | Read & Sign Physician Authorization

I certify that I am the physician who has prescribed EXTAVIA to the previously identified patient and that I have provided the patient with a description of the EXTAVIA *Go Program*. I consent to the Novartis Group using my prescribing information and contacting me for its marketing and other internal business purposes.

X _____ _____
Prescriber Signature **MM/DD/YYYY**

STEP 5 | Read & Sign Patient Authorization

I have read and agree to the Patient Authorization Section A on Page 1 of this document. ***(Signature required)***

X _____ _____
Patient/Legal Guardian Signature **MM/DD/YYYY**

☐ **The signature above also denotes that I have read and agree to the Patient Marketing Consent Section B on Page 1 of this document.** ***(Participation optional)***

Indication

EXTAVIA (interferon beta-1b) is indicated for the treatment of relapsing forms of multiple sclerosis to reduce the frequency of clinical exacerbations. Patients with multiple sclerosis in whom efficacy has been demonstrated include patients who have experienced a first clinical episode and have MRI features consistent with multiple sclerosis.

Important Safety Information

EXTAVIA is contraindicated in patients with a history of hypersensitivity to natural or recombinant interferon beta, albumin (human), USP, or any other component of the formulation.

Please see additional Important Safety Information on reverse side.
Please see accompanying full Prescribing Information.

EXTAVIA® interferon beta-1b FOR SC INJECTION

Important Safety Information

EXTAVIA is contraindicated in patients with a history of hypersensitivity to natural or recombinant interferon beta, albumin (human), USP, or any other component of the formulation.

EXTAVIA should be used with caution in patients with depression. Depression and suicide have been reported to occur with increased frequency in patients receiving interferon compounds, including EXTAVIA. Patients treated with EXTAVIA should be advised to immediately report any symptoms of depression and/or suicidal ideation. Consider discontinuation of EXTAVIA if depression occurs.

Injection site necrosis has been reported in 4% of patients in controlled clinical trials. Injection site reactions occurred in 78% of patients receiving EXTAVIA. Patients should be advised of the importance of rotating injection sites and the use of aseptic self-injection techniques.

Anaphylaxis has been reported as a rare complication of EXTAVIA use.

The rate of flu-like symptom complex was approximately 57%. The incidence decreased over time, with only 10% of patients reporting flu-like symptom complex at the end of the studies. Concurrent use of analgesics and/or antipyretics may help ameliorate flu-like symptoms on treatment days. Leukopenia was reported in 18% of patients. Hepatic enzyme elevations of SGPT to greater than five times baseline value were reported in 12% of patients and increases of SGOT to greater than five times baseline value were reported in 4% of patients leading to dose reduction or discontinuation of EXTAVIA in some patients.

Monitoring of certain lab tests is recommended following initiation of EXTAVIA therapy, including complete blood count and liver function tests. In patients with a history of thyroid dysfunction, thyroid function tests are recommended every six months.

EXTAVIA should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus.

The most common adverse reactions (at least 2% more than placebo) with EXTAVIA were: lymphopenia (66% vs 86%), neutropenia (5% vs 13%), leukopenia (4% vs 13%), lymphadenopathy (3% vs 6%), headache (43% vs 50%), insomnia (16% vs 21%), incoordination (15% vs 17%), hypertension (4% vs 6%), dyspnea (3% vs 6%), abdominal pain (11% vs 16%), increased liver enzymes (up to 4% vs up to 12%), rash (15% vs 21%), skin disorder (8% vs 10%), hypertonia (33% vs 40%), myalgia (14% vs 23%), urinary urgency (8% vs 11%), metrorrhagia (7% vs 9%), impotence (6% vs 8%), injection site reaction (26% vs 78%), asthenia (48% vs 53%), flu-like symptom complex (37% vs 57%), pain (35% vs 42%), fever (19% vs 31%), chills (9% vs 21%), peripheral edema (10% vs 12%), chest pain (6% vs 9%), malaise (3% vs 6%), and injection site necrosis (0% vs 4%).

Please see additional Important Safety Information on reverse side.
Please see accompanying full Prescribing Information.

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