# *Service Request Form and Prescriptions* **FAX: 1-877-428-5889;** *PHONE: 1-800-GILENYA (1-800-445-3692)*

***Please complete all fields to prevent any delays.*** *Please include copies of both sides of insurance card.*

## 1. Patient and Insurance Information

**First Name** **Last Name**

Sex: ☐M ☐F Date of Birth (MM/DD/YYYY)

Address

City State ZIP

Home Phone Cell Phone **(important)**

E-mail address **(can help speed up the process)**

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

☐ OK to leave a message

☐ The signature to the right also denotes that I have read and agree to the attached **Patient Marketing Consent Section B**. (Participation optional)

**Primary Insurance Name**

Beneficiary/Cardholder Name

Primary Insurance ID # Group #

Primary Insurance Phone

**Prescription Insurance Name**

Prescription Insurance ID # Phone

I have read and agree to the attached **Patient Authorization Section A**. **(Signature required)**

X

***Patient/Legal Guardian Signature*** ***Date (MM/DD/YYYY)***

FOR OFFICE USE ONLY

## 2. Physician Information

First Name Last Name

Site Name

Address

City State ZIP

Phone Fax

State Medical License # NPI #

Office Contact Name Office Contact Phone

E-mail Address

## 3. Patient Selection Assessment Completed

☐YES ☐NO **First-Dose Observation Date:**_____

*Ophthalmologic evaluation is not offered through the GAN. GAN sites perform ECGs in support of the FDO, but do not conduct complete cardiac evaluations.

†Free to eligible commercially insured and uninsured patients; Medicare is accepted at most GAN sites; there is a cash-pay option for residents of MA, MI, RI, or MN.

‡This offer is not valid for medical assessments for which payment may be made in whole or in part under federal or state health programs, including but not limited to Medicare or Medicaid, or for residents of Massachusetts, Michigan, Rhode Island, or Minnesota. This program is subject to termination or modification at any time.

## 4. Assessment Assistance Required

☐ **YES** (Assistance through the GILENYA Assessment Network—**Check those that apply**) ☐ **NO** (Benefit Investigation and RX Only)

**A. Patient Selection**[*†‡]

**BLOOD TESTS:** ☐CBC ☐LFTs and bilirubin ☐VZV antibody serology ☐ECG

**B. GILENYA Treatment Initiation**[†‡] ☐First-dose observation (FDO)

## 5. Starter Product Rx (14-Day Supply) (Optional, at no cost to patient) Dispensed directly from the GILENYA *Go Program*

☐ **Dispense 2 boxes GILENYA** (7 capsules per box) **followed by up to 3 refills**

Indicate ICD-9 code: _____

***To be taken:*** _____

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge. I certify that I am the physician who has prescribed GILENYA to the previously identified patient and that I have provided the patient with a description of the GILENYA *Go Program*.

X

***Prescriber Signature*** ***Date***

**Starter product shipping address** (check one or fill in below):

☐Physician's address ☐Physician's FDO site on file ☐Patient's address

☐Other address (provide below) ☐GILENYA Assessment Network site

Site Name Contact Name

Address Office Hours

City State ZIP Phone

## 6. Ongoing Rx (Please provide required prior authorization documents)

**Dispense (check one):**

☐ **1 box** (28 capsules per box) **followed by 11 refills**

☐ **3 boxes** (28 capsules per box) **followed by 3 refills**

Indicate ICD-9 code: _____

***To be taken:*** _____

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge. I certify that I am the physician who has prescribed GILENYA to the previously identified patient and that I have provided the patient with a description of the GILENYA *Go Program*.

X

***Prescriber Signature*** ***Date***

***Notes:***



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



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

## 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 (including sales force representatives), 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 GILENYA, (ii) coordinate my receipt of, and payment for GILENYA, (iii) facilitate the administration of GILENYA to me, (iv) provide information about GILENYA, disease awareness, management programs and educational materials to me, (v) manage the GILENYA Support Program as described to me by my doctor(s), and (vi) conduct market research, quality assurance, resource allocation, and other internal business activities. I authorize the Novartis Group to disclose my Personal Information to any pharmacies, insurance carriers, 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 understand that I may choose the dispensing pharmacy in accordance with my insurance and/or prescriber recommendation. I authorize the Novartis Group to contact me directly for the purposes described above. I agree to receive GILENYA *Go Program* phone calls, text messages, e-mails, and mailing materials from the Novartis Group at the number(s) and address(es) provided. I understand that my cell phone carrier's standard rates may apply for calls or text messages received at the numbers provided.

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), nor my employer, nor my health insurer can guarantee that it will not be redisclosed 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, if I revoke this authorization, I may no longer be eligible to participate in the GILENYA *Go 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 1-877-408-4974. I also understand that the GILENYA *Go Program* may be changed or ended at any time without prior notification and that I may receive a copy of this authorization.

## B. Patient Marketing Consent

I would also like to receive marketing information, offers, and promotions from Novartis Pharmaceuticals Corporation regarding its products, programs, and services, and 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 Corporation will be shared with and among its business partners to provide me with Novartis-specific products, programs, services, and/or to conduct market research. I understand that Novartis Pharmaceuticals Corporation does not permit my Personal Information to be used by any of its business partners for their own separate marketing purposes. I agree to receive phone calls, text messages, e-mails, and mailing materials from Novartis Pharmaceuticals Corporation at the number(s) and address(es) provided. I understand that my cell phone carrier's standard rates may apply for calls or text messages received at the numbers provided. I may cancel my participation at any time by calling 1-877-408-4974. I understand that Novartis Pharmaceuticals Corporation will use my personal information in accordance with this Marketing Consent and the privacy statement at www.novartis.com.



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