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

Novartis Patient Support™

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* = REQUIRED

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

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

☐ **Access and Reimbursement Support**
- Check insurance coverage for ZOLGENSMA, including non-emergency travel and prior authorization and appeals support

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

☐ **Copay Support**
- Enrollment in the ZOLGENSMA CopayAssist™ Program
- **Caregiver must agree to and check the Copay Support box in Section 4 below**

☐ **Caregiver Support Calls**
- Dedicated phone support to help caregivers navigate the process before and after treatment with ZOLGENSMA
- **Caregiver must opt into support calls by checking the Caregiver Support Calls box in Section 4 below**

☐ **All** of the optional services listed above

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 *We'll keep the Parent/Legal Representative informed through non-marketing calls and texts.**

OK to Leave Voicemail About ZOLGENSMA: ☐ Yes ☐ No

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

* City _____ * State _____ * ZIP _____ Email _____

3 Additional Caregiver Information for 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 non-marketing calls and texts.**

Additional Caregiver Name _____ Relationship to Patient _____ Caregiver Phone Number _____ ☐ Mobile ☐ Home *We'll keep the Caregiver informed through non-marketing calls and texts.**

4 Patient Authorization and Additional Enrollment Consents

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

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

X _____

* **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 3 of this resource.

CAREGIVER SUPPORT CALLS

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

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.

Do Not Fax Patient Medical Records.

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* = REQUIRED

* Patient Name (First Name and Last Name) _____ * Date of Birth (MM/DD/YYYY) _____

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 ☐ 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 ☐ Other: _____

Insurance Provider _____ Phone Number _____

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

Policy ID Number _____ Group Number _____

6 Prescriber Information

* Prescriber Name _____ * Prescriber NPI Number _____ * Prescriber Email _____

* 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 Infusion Date (MM/DD/YYYY): _____ Patient Current/Prior SMA Treatment (Medication): _____ ☐ Treatment-Naive

Most Recent Patient Weight: _____ (kg) Date of Most Recent Patient Weight (MM/DD/YYYY): _____

* **Primary Diagnosis ICD-10-CM Code** ☑ G12.0 Infantile SMA Type 1 (Werdnig-Hoffman)

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

8 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 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

* **Prescriber Signature** _____ * **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 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.

*Novartis Patient Support may call and text you at the numbers provided for non-marketing purposes (eg, to help you access and start on ZOLGENSMA). 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.** 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.

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

Do Not Fax Patient Medical Records.

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