Kesimpta®
(ofatumumab) 20 mg injection

Your doctor has prescribed KESIMPTA®

Welcome to the Alongside™ KESIMPTA® program.
By enrolling, here's what happens next:

We'll check your benefits

- Expect a call from us to discuss your options, including potential savings and product delivery

We'll mail you a welcome package

- With some important information about your program and quick tips for using KESIMPTA. It should arrive in a day or two

You'll get a call from your dedicated Coordinator

- Who has access to your membership materials, additional training resources, and answers to any questions you may have

We're in this together.

Questions?
Call us at 1-855-KESIMPTA (1-855-537-4678)
8:30 AM–8:00 PM ET, Monday–Friday

Visit www.KESIMPTA.com for more information

Alongside™
Kesimpta®
(ofatumumab) 20 mg injection

KESIMPTA®
Prescription Start Form

Send Fax
1-833-318-0680

Enroll Online
CoverMyMeds.com

Questions? Call
1-855-KESIMPTA
(1-855-537-4678)

Kesimpta® (ofatumumab) 20 mg injection

1 Patient Information

First Name | Last Name | Email

Sex: ☐ M ☐ F | Date of Birth (MM/DD/YYYY) / / | Home Phone | Cell Phone

Address (No PO Box)

OK to leave voicemail on: ☐ Home Phone ☐ Cell Phone

City | State | ZIP

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

2 Patient Authorization and Additional Consents

I have read and agree to the Patient Authorization on page 2.

→ X _____ **Patient/Legal Guardian Signature** | / / **Date of Signature** (MM/DD/YYYY)

KESIMPTA Copay Card Program

☐ I have read and agree to the Copay Program Terms and Conditions on page 2.

Determine financial eligibility

Novartis Patient Assistance Foundation, Inc., (NPAF) provides free KESIMPTA to eligible uninsured and underinsured patients. Proof of income is required. If you choose to apply for free KESIMPTA, checking the box below will prompt NPAF to verify your income.

☐ I have read and agree to the Fair Credit Reporting Act (FCRA) Authorization on page 2.

Ongoing Support from Alongside KESIMPTA

We'll check in with you via calls and texts to support your start with KESIMPTA.† You can also get continued one-on-one support with a dedicated Alongside KESIMPTA Coordinator by checking the box below.

☐ I want to receive recurring reminders, tips, and other communications via calls and texts at the phone number provided. I understand calls or texts may be autodialed or prerecorded and are not a condition of purchase.

3 Insurance Information *(Please include a copy of both sides of the insurance card)*

Cardholder Name | Prescription Cardholder Name

Insurance Carrier | Phone Number | Rx Insurance Carrier | Rx Phone Number

Cardholder ID Number | Group Number | Rx BIN Number | Rx PCN Number

Rx Group Number | Rx ID Number

4 Provider Information

First Name | Last Name | Business Practice Name

Address (No PO Box) | Office Contact Name

City | State | ZIP | Office Contact Phone | Office Fax

NPI Number | Email

5 Prescription Information

Specialty Pharmacy:
AcariaHealth Specialty Pharmacy
Preferred Specialty Pharmacy

800.511.5144 | 877.541.1503
Phone | Fax

Diagnosis Code: ☐ ICD-10: G35 Multiple Sclerosis
☐ Other: _____

Shipping Preferences:

First Dose: ☐ Provider Address ☐ Patient Address

Supplemental Injection Demonstration: ☐

Pharmacy Prescription:

Loading Doses:

☐ No, patient already on therapy
☐ Yes, 20 mg (0.4 mL)
Qty: 3 units (0.4 mL)
1 SQ injection
at week 0, 1, and 2

☐ **Maintenance Dose:**
20 mg (0.4 mL)
1 SQ injection monthly starting
at week 4
Qty: 1 SQ injection, then
12 refills, or _____ months' supply

Bridge to Commercial Coverage:

Eligible patients receive KESIMPTA for free while pursuing insurance coverage. Must have commercial insurance, a valid prescription for KESIMPTA, and a denial of insurance coverage based on a prior authorization request to qualify.*

Loading Doses:

☐ No, patient already on therapy
☐ Yes, 20 mg (0.4 mL)
Qty: 3 units (0.4 mL)
1 SQ injection at week 0, 1, and 2

☐ **Maintenance Dose:**
20 mg (0.4 mL)
1 SQ injection monthly starting at week 4
Qty: 1 SQ injection, then 12 refills,
or _____ months' supply

6 Provider Attestation

Prescriber must authorize these instructions by signing at the end of this section.

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 KESIMPTA to the previously identified patient and I provided the patient with a description of Alongside KESIMPTA. I certify in-office injection guidance will be provided. For the purposes of transmitting these prescriptions, I authorize NPAF, Novartis Pharmaceuticals Corporation, and its affiliates, business partners, and agents to forward as my agent, for these limited purposes, the prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies. I will not attempt to seek reimbursement for free product provided to my office.

→ X _____ **Provider Signature** | _____ **Substitution Permissible** | / / **Date of Signature** (MM/DD/YYYY)

ATTN: New York and Iowa providers, please submit electronic prescription to Homescripts Pharmacy NPI #1528362076.

SQ=subcutaneous.

*Submission of request for coverage within 9 months of enrollment required. Patients may receive monthly maintenance dose for up to 12 months, or until insurance coverage approval, whichever occurs first. Not available to patients who are uninsured or whose medications are reimbursed in whole or in part by Medicare, Medicaid, TRICARE, or any other federal or state program, or where prohibited by law. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Other limitations may apply. Novartis reserves the right to rescind, revoke, or amend the Program at any time without notice.

Complete entire form and fax to Alongside KESIMPTA at 1-833-318-0680

Patient Authorization. I authorize my healthcare providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment and prescription details ("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 support services (the "Services"):

- Help coordinate insurance coverage for, access to, and receipt of my medication.
- Communicate with me about possible financial assistance, including Novartis copay or NPAF programs, and, if I am enrolled, administer my participation in those programs.
- Communicate with me about my medication and treatment, including reminders, health and lifestyle tips, and product and other related information. Communications may be customized based on Personal Information obtained from my Providers.
- 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 Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with information collected from other sources and use that information to administer the Services. My pharmacies or other healthcare providers may receive payment from Novartis or NPAF for providing certain Services, such as medication or refill reminders, based on my enrollment or participation. Once I authorize disclosure of my 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 my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling 1-855-537-4678 or writing to:

PO Box 2971
850 Twin Rivers Dr
Columbus, OH, 43216-9532

OR

Customer Interaction Center
Novartis Pharmaceuticals Corporation
One Health Plaza
East Hanover, NJ 07936-1080

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

Copay Program Terms and Conditions

Limitations apply. Valid only for those with private insurance. The Program includes the [copay card] and Rebate, with a combined annual limit of [$18,000]. 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 toward 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.

Fair Credit Reporting Act (FCRA) Authorization

I understand that I am providing "written instructions" that authorize NPAF and its vendor, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for programs administered by NPAF. I understand that I must affirmatively agree to these terms in order to proceed with this financial screening process.

†Alongside KESIMPTA may call and text you at the numbers provided for non-marketing purposes (e.g., to help you access and start on KESIMPTA). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 1-855-537-4678.

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NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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