Novartis
Patient Support™

Guide to completing the VANRAFIA® (atrasentan) Start Form

Phone:
844-4VANRAF (844-482-6723)

Fax:
877-6VANRAF (877-682-6723)

Online:
vanrafia-startform.com

Portal:
www.covermymeds.health

For questions or support, reach out to your dedicated Access and Reimbursement Team or contact Novartis Patient Support.

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

VANRAFIA™
(atrasentan) tablets
0.75 mg

Novartis
Patient Support

Getting patients started

Novartis Patient Support will work with your practice to help your patient start on VANRAFIA. Begin the process by completing the Start Form. We have outlined the key information below to help ensure a smoother process for your office and your patient.

All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

Look for this symbol ★ as you fill out the Start Form. It indicates a required field.

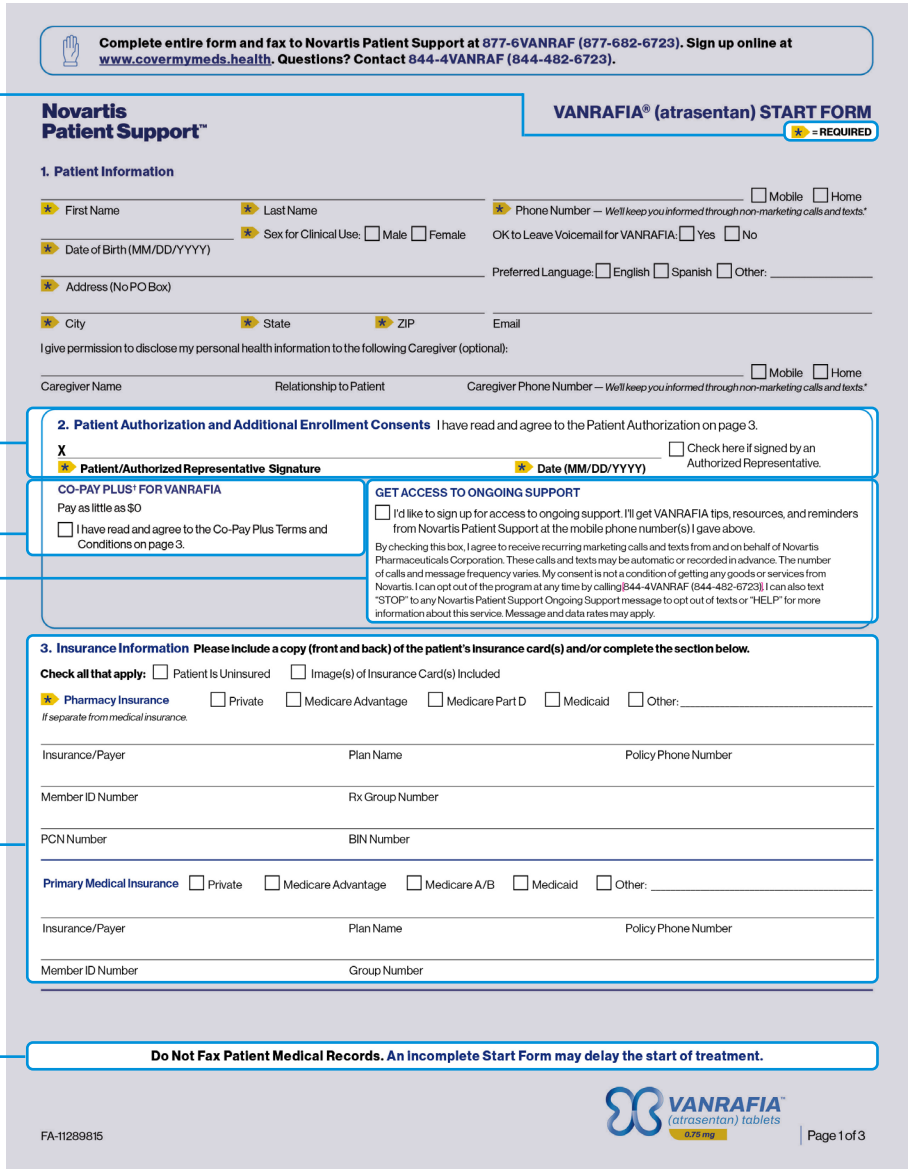
Get patient and/or authorized representative consent.

Patients can check this box to sign up for the Co-Pay Plus offer.

Patients can check this box to opt into ongoing support.

Don't forget your patient's insurance information. We need to verify all their benefits.

Please **do not fax patient medical records**.



Page 1

Complete entire form and fax to Novartis Patient Support at 877-6VANRAF (877-682-6723). Sign up online at www.covermymeds.health. Questions? Contact 844-4VANRAF (844-482-6723).

Novartis Patient Support™

VANRAFIA® (atrasentan) START FORM

★ = REQUIRED

1. Patient Information

★ First Name ★ Last Name ★ Phone Number — *We'll keep you informed through non-marketing calls and texts.** ☐ Mobile ☐ Home

★ Date of Birth (MM/DD/YYYY) ★ Sex for Clinical Use: ☐ Male ☐ Female OK to Leave Voicemail for VANRAFIA: ☐ Yes ☐ No

★ Address (No PO Box) Preferred Language: ☐ English ☐ Spanish ☐ Other:

★ City ★ State ★ ZIP Email

I give permission to disclose my personal health information to the following Caregiver (optional):

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

2. Patient Authorization and Additional Enrollment Consents I have read and agree to the Patient Authorization on page 3.

X ★ Patient/Authorized Representative Signature ★ Date (MM/DD/YYYY) ☐ Check here if signed by an Authorized Representative.

CO-PAY PLUS† FOR VANRAFIA

Pay as little as $0

☐ I have read and agree to the Co-Pay Plus Terms and Conditions on page 3.

GET ACCESS TO ONGOING SUPPORT

☐ I'd like to sign up for access to ongoing support. I'll get VANRAFIA 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 844-4VANRAF (844-482-6723). I can also text "STOP" to any Novartis Patient Support Ongoing Support message to opt out of texts or "HELP" for more information about this service. Message and data rates may apply.

3. 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 Uninsured ☐ Image(s) of Insurance Card(s) Included

★ **Pharmacy Insurance** ☐ Private ☐ Medicare Advantage ☐ Medicare Part D ☐ Medicaid ☐ Other:

If separate from medical insurance.

Insurance/Payer Plan Name Policy Phone Number

Member ID Number Rx Group Number

PCN Number BIN Number

Primary Medical Insurance ☐ Private ☐ Medicare Advantage ☐ Medicare A/B ☐ Medicaid ☐ Other:

Insurance/Payer Plan Name Policy Phone Number

Member ID Number Group Number

Do Not Fax Patient Medical Records. An Incomplete Start Form may delay the start of treatment.

VANRAFIA (atrasentan) tablets 0.75 mg

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VANRAFIA™ (atrasentan) tablets 0.75 mg

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Getting patients started (cont)

All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

Make sure your patient's name and date of birth are present at the top of page 2.

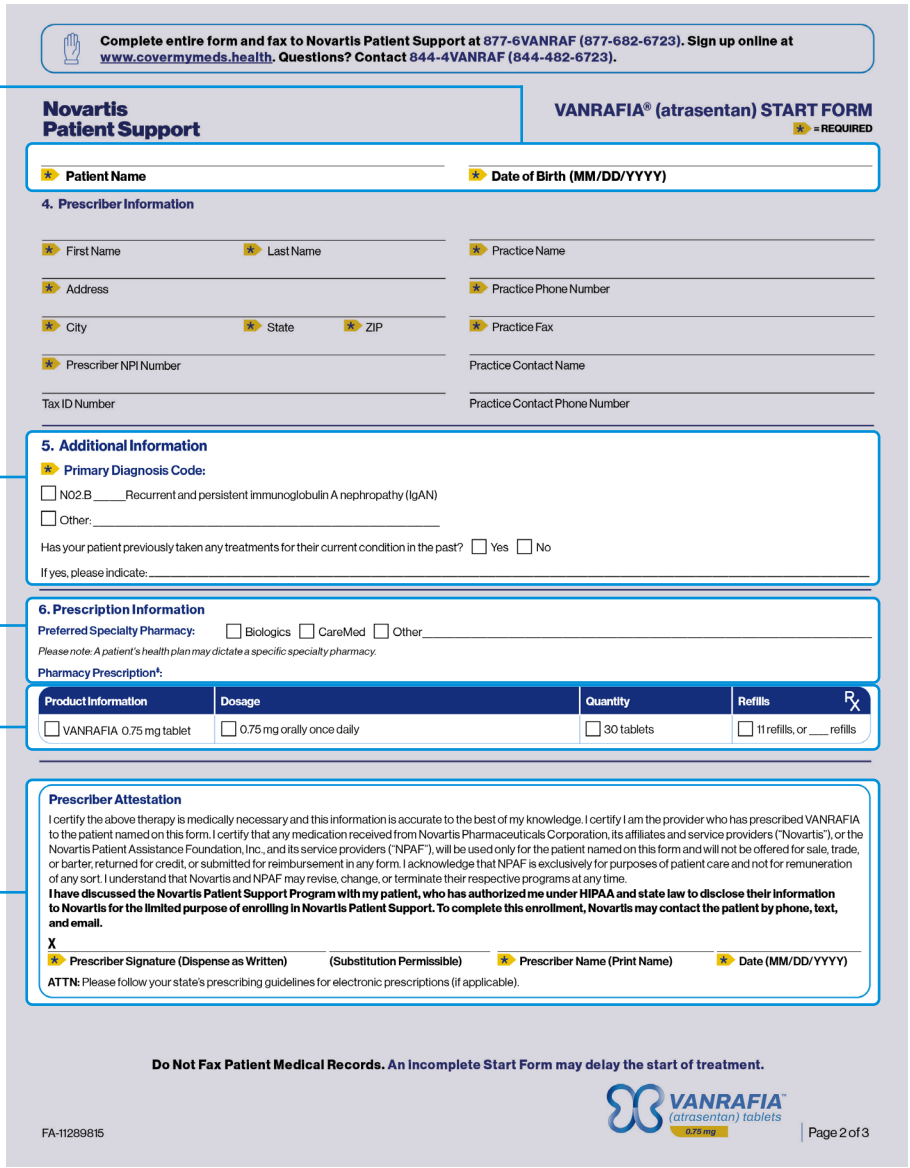
It's important to review and capture all necessary information prior to initiating therapy:

- Indicate the applicable primary diagnosis code(s) for your patient here

Indicate your patient's Preferred Specialty Pharmacy.

Complete the Pharmacy Prescription table.

Please don't forget to sign and date the provider attestation.



Page 2

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Novartis Patient Support

VANRAFIA® (atrasentan) START FORM

★ = REQUIRED

★ Patient Name ★ Date of Birth (MM/DD/YYYY)

4. Prescriber Information

★ First Name ★ Last Name ★ Practice Name

★ Address ★ Practice Phone Number

★ City ★ State ★ ZIP ★ Practice Fax

★ Prescriber NPI Number Practice Contact Name

Tax ID Number Practice Contact Phone Number

5. Additional Information

★ Primary Diagnosis Code:

☐ N02.B _____Recurrent and persistent immunoglobulin A nephropathy (IgAN)

☐ Other: _____

Has your patient previously taken any treatments for their current condition in the past? ☐ Yes ☐ No

If yes, please indicate: _____

6. Prescription Information

Preferred Specialty Pharmacy: ☐ Biologics ☐ CareMed ☐ Other _____

Please note: A patient's health plan may dictate a specific specialty pharmacy.

Pharmacy Prescription[4]:

Product Information	Dosage	Quantity	Refills ℞
☐ VANRAFIA 0.75 mg tablet	☐ 0.75 mg orally once daily	☐ 30 tablets	☐ 11 refills, or ___ refills

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 VANRAFIA 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 the Novartis Patient Support Program 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 (Dispense as Written) (Substitution Permissible) ★ Prescriber Name (Print Name) ★ Date (MM/DD/YYYY)

ATTN: Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).

Do Not Fax Patient Medical Records. An incomplete Start Form may delay the start of treatment.

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VANRAFIA (atrasentan) tablets 0.75 mg

Page 2 of 3

VANRAFIA™ (atrasentan) tablets 0.75 mg

Novartis Patient Support

Your patients are our top priority

Not an actual patient.

Novartis Patient Support is a comprehensive program that is designed to help your eligible patients start, stay, and save on VANRAFIA.

We support you and your patient's journey with:

- Dedicated assistance with access and reimbursement
- Personalized support for your patients on therapy
- Single points of contact for you and your patients

Our offerings include:

Insurance Support

Help navigating the insurance process, including benefits verification and support with the prior authorization and appeals processes.

Financial Support

Assistance with relevant savings options for your eligible patients, such as Co-Pay Plus offer* and Bridge Program.

Ongoing Support

Dedicated assistance from our team and educational resources to help your patients get started on treatment and guide them along the way.

Questions?

For more information, call Novartis Patient Support at 844-4VANRAF (844-482-6723), Monday-Friday, 8:00 AM-8:00 PM ET, excluding holidays or visit **www.vanrafia.com**.

***Limitations apply.** Up to a 15,000 annual limit. Offer not valid under Medicare, Medicaid, or any other federal or state health insurance program. Patients with private insurance and a prior authorization requirement or an initial denial of coverage may receive up to 12 months of free product while coverage is pursued. Novartis reserves the right to rescind, revoke, or amend this program without notice. Additional limitations may apply. See complete Terms & Conditions at www.vanrafia.com for details.

The information herein is provided for educational purposes only. Novartis cannot guarantee health plan or reimbursement. Coverage and reimbursement may vary significantly by health plan, patient, and setting of care. It is the sole responsibility of the health care provider to select the proper codes and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient.

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VANRAFIA™ (atrasentan) tablets 0.75 mg

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

4/25

FA-11289815

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Novartis Patient Support™

VANRAFIA® (atrasentan) START FORM

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1. Patient Information

* First Name
* Last Name
* Phone Number — *We'll keep you informed through non-marketing calls and texts.** ☐ Mobile ☐ Home
* Date of Birth (MM/DD/YYYY)
* Sex for Clinical Use: ☐ Male ☐ Female
OK to Leave Voicemail for VANRAFIA: ☐ Yes ☐ No
* Address (No PO Box)
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____
* City
* State
* ZIP
Email

I give permission to disclose my personal health information to the following Caregiver (optional):

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

2. Patient Authorization and Additional Enrollment Consents

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

X _____ ☐ Check here if signed by an Authorized Representative.

* **Patient/Authorized Representative Signature**
* **Date (MM/DD/YYYY)**

CO-PAY PLUS† FOR VANRAFIA

Pay as little as $0

☐ I have read and agree to the Co-Pay Plus Terms and Conditions on page 3.

GET ACCESS TO ONGOING SUPPORT

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3. 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 Uninsured ☐ Image(s) of Insurance Card(s) Included

* **Pharmacy Insurance** ☐ Private ☐ Medicare Advantage ☐ Medicare Part D ☐ Medicaid ☐ Other: _____

If separate from medical insurance.

Insurance/Payer | Plan Name | Policy Phone Number

Member ID Number | Rx Group Number

PCN Number | BIN Number

Primary Medical Insurance ☐ Private ☐ Medicare Advantage ☐ Medicare A/B ☐ Medicaid ☐ Other: _____

Insurance/Payer | Plan Name | Policy Phone Number

Member ID Number | Group Number

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Novartis Patient Support

VANRAFIA® (atrasentan) START FORM

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* Patient Name

* Date of Birth (MM/DD/YYYY)

4. Prescriber Information

* First Name

* Last Name

* Practice Name

* Address

* Practice Phone Number

* City

* State

* ZIP

* Practice Fax

* Prescriber NPI Number

Practice Contact Name

Tax ID Number

Practice Contact Phone Number

5. Additional Information

* **Primary Diagnosis Code:**

☐ N02.B _____Recurrent and persistent immunoglobulin A nephropathy (IgAN)

☐ Other: _____

Has your patient previously taken any treatments for their current condition in the past? ☐ Yes ☐ No

If yes, please indicate: _____

6. Prescription Information

Preferred Specialty Pharmacy: ☐ Biologics ☐ CareMed ☐ Other _____

Please note: A patient's health plan may dictate a specific specialty pharmacy.

Pharmacy Prescription‡:

Product Information	Dosage	Quantity	Refills ℞
☐ VANRAFIA 0.75 mg tablet	☐ 0.75 mg orally once daily	☐ 30 tablets	☐ 11 refills, or ___ refills

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 VANRAFIA 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 the Novartis Patient Support Program 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 (Dispense as Written)** | **(Substitution Permissible)** | * **Prescriber Name (Print Name)** | * **Date (MM/DD/YYYY)**

ATTN: Please follow your state's prescribing guidelines for electronic prescriptions (if applicable).

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Patient Support

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 844-4VANRAF (844-482-6723) or by writing to:

Novartis Patient Support
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.

*Novartis Patient Support may call and text you at the numbers provided for non-marketing purposes (eg, to help you access and start on VANRAFIA). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 844-4VANRAF (844-482-6723).

†**Limitations apply.** Valid only for those with private insurance. The Program includes the Co-Pay Plus offer, Plus Card (if applicable), and Rebate, with a combined annual limit up to $15,000. 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 co-payments, 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.

‡**The Bridge Program applies to VANRAFIA only.** Eligible patients must have private insurance and a valid prescription for VANRAFIA, and a prior authorization or an initial denial of coverage. Program requires the submission of an appeal of the coverage denial within the first 90 days of enrollment to remain eligible. Program provides VANRAFIA for free to eligible patients for up to 12 months, or until they receive insurance coverage approval, whichever occurs earlier. A valid prescription consistent with FDA-approved labeling is required. Program is not available to patients whose medications are reimbursed in whole or in part by Medicare, Medicaid, TRICARE, or any other federal or state program. Patients may be asked to reverify insurance coverage status during the course of the program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Additional Limitations may apply. Novartis Pharmaceuticals Corporation reserves the right to rescind, revoke, or amend this Program without notice.

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

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

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