NOVARTIS
P. O. Box 66556
St. Louis, MO 63166-6556

Dear Patient or Health Care Provider:

Thank you for your interest in the Novartis Patient Assistance Foundation, Inc. ("Foundation"). To be eligible for the Novartis Patient Assistance Foundation Program ("NPAFP") patients must be a U.S. resident, meet the income requirements, and must not have prescription drug coverage. Please complete the following steps to apply for the NPAFP.

1.) Complete all patient and physician sections of the attached application.
2.) Attach an original prescription for the requested medication (except Retail Card products).
3.) Attach a copy of your most recent year federal tax return or financial documentation.
Some examples include:

- IRS Form 1040, 1040EZ
- 1099 Social Security Statement
- Paycheck stubs
- W-2 Forms

4.) Mail the Application, Prescription, and Financial Documentation to:

NOVARTIS PATIENT ASSISTANCE FOUNDATION, INC.
PO BOX 66556
ST. LOUIS, MO 63166-6556

We will review and process the patient's eligibility once we receive the completed application, prescription and supporting financial documentation. You will receive written notification concerning the patient's eligibility.

The following products are offered on the NPAFP.

Comtan® (entacapone)
Diovan® (valsartan)
Diovan HCT® (valsartan hydrochlorothiazide)
Elidel®* (pimecrolimus)
Enablex® (darifenacin)
Exelon® (rivastigmine tartrate)
Exelon® Patch (rivastigmine transdermal system)
Exforge® (amlodipine and valsartan)
Focalin® XR (Retail Card) (dexmethylphenidate HCl extended release)
Lamisil® Oral Granules (terbinafine hydrochloride)
Lescol® (fluvastatin sodium)
Lescol® XL (fluvastatin sodium extended release)
Miacalcin®* (calcitonin-salmon)
Ritalin LA® (Retail Card) (methylphenidate HCl)
Stalevo® (carbidopa, levodopa and entacapone)
Starlix® (nateglinide)
Tegretol®-XR (carbamazepine extended release)
Tekturna® (aliskiren)
Tekturna HCT® (aliskiren and hydrochlorothiazide)

For any other Novartis Pharmaceuticals product not listed, please call 1-800-277-2254.

The majority of products are dispensed in 90-day supplies. All products will be shipped directly to the physician's office (except for Retail Card products***).

If you have any questions, please call a NPAFP representative at 1-800-277-2254, Monday through Friday, 9:00 am to 6:00 pm EST.

Sincerely,

Novartis Patient Assistance Foundation, Inc.

*Medications are dispensed in 30-day supplies
***In the case of Retail Card products such as Focalin XR and Ritalin LA, a pharmacy card will be sent to the patient. The patient must take the pharmacy card and a valid prescription to their retail pharmacy to receive the product.

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Novartis Patient Assistance Foundation, Inc. ("Foundation") Enrollment Application

IMPORTANT: A VALID PRESCRIPTION AND PATIENT FINANCIAL DOCUMENTATION MUST BE ATTACHED TO PROCESS THIS APPLICATION.
DO NOT SEND ORIGINAL COPIES OF FINANCIAL DOCUMENTATION AS THEY WILL BECOME PROPERTY OF THE NPAFP

PATIENT INFORMATION

Patient Name:		**SSN/ID No:**
Address:		**Date of Birth:**
City:	**State:**	**Zip:**
Phone Number: ( )	**Gender:** ❑ **Male** ❑ **Female**	

Number of people in household (including self)? Circle One: 1 2 3 4 5 6 or more

US Resident	**Are you a Veteran of the US Armed Forces?**	**Have you received disability payments from Social Security for more than 24 months?**
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

MEDICATION INFORMATION

❑ *Focalin® XR (dexmethylphenidate HCl extended release)
❑ *Ritalin LA® (methylphenidate HCl)
***Patient must bring the issued retail pharmacy card, along with the prescription, to the pharmacy.**

❑ Other - Please specify requested product(s):

_____

* **Please attach a valid prescription.**

FINANCIAL INFORMATION- Attach a copy of your most recent federal tax return or other supporting financial documentation. Income examples: 1040, 1040EZ, 1040X, 1099

List all sources, Gross Monthly Amounts

Salary/Wages	$ _____	Social Security	$_____
Disability	$ _____	Pension/Retirement	$_____
Alimony/Child Support	$_____	Unemployment/Work Comp	$_____

Total Gross Household Monthly Income: $_____

Total Patient Household Assets (excludes first home and car): $_____

ATTACH PROOF OF INCOME
(Do Not Send Original Copies)

INSURANCE INFORMATION

Private Prescription Drug Coverage		Medicaid
❑ Yes ❑ No	Medicare ❑ Yes ❑ No (if Yes, please check all that apply) Medicare Part A ❑ Medicare Part B ❑ Medicare Part D ❑	❑ Yes ❑ No

I authorize the Foundation and its affiliates and agents (collectively "Novartis") to use and/or disclose among Novartis the information on this Enrollment Application and any other information I provide to Novartis in relation to the Novartis Patient Assistance Foundation Program ("My Information") to determine if I am eligible to participate in the Novartis Patient Assistance Foundation Program("NPAFP") and for the operation and administration of the NPAFP. I further authorize Novartis to disclose My Information to governmental agencies, including the Centers for Medicare and Medicaid Services, and to insurance plans, including Medicare Part D plans ("Government") and that they may disclose My Information to and among themselves and Novartis in furtherance of the activities and administration of the NPAFP. By signing below I verify that the information on this application, including the signed copy of my prior year's tax return and other supporting documentation is complete and accurate. I also verify that unless I have identified otherwise in this application, I have no other coverage for prescription medications, including Medicaid, Medicare or any public or private assistance programs or any other form of insurance. I also agree that Novartis may verify my eligibility for the NPAFP, and understand that such verification may include contacting me or my health care provider for additional information and/or reviewing additional financial, insurance, and/or medical information. In connection with administering the NPAFP, I understand that Novartis may contact me or my health care provider directly to confirm receipt of medications or to provide other information related to the NPAFP. I also understand that Novartis may revise, change, or terminate the NPAFP at any time. I understand that if I refuse to sign this authorization, I w ill not be able to participate in the NPAFP, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance coverage. Further, I understand that I can cancel this authorization at any time by contacting the Novartis NPAFP, but if I do so I will no longer be eligible for the NPAFP.

Signature of Patient or Legal guardian (*Required to process application*)	**Date**
X	

PHYSICIAN INFORMATION – All product will be shipped to the physician's office.

Physician Name:		**DEA/State License No:**
Address:		
City:	**State:**	**Zip:**
Phone: ( )	**Fax: ( )**	

My signature below certifies that the person listed above is my patient for whom I have prescribed the drug identified above. I certify that any medications received from Novartis (as defined above) in connection with this application will be used only for the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor will any medications be returned for credit. I acknowledge that I have assisted the patient in enrolling in the Novartis NPAFP exclusively for purposes of patient care and not inconsideration for, expectation of, or actual receipt of remuneration of any sort. I also agree that Novartis has the right to contact the patient directly to confirm receipt of medications, and I understand that Novartis may revise, change, or terminate this program at any time. Finally, to the best of my knowledge, the patient listed above meets Novartis' eligibility criteria for the NPAFP.

Signature of Physician *(Required to process application)*	**Date:**
X	

PLEASE CALL 1-800-277-2254 WITH ANY QUESTIONS