NOVARTIS | PATIENT ASSISTANCE FOUNDATION, INC.

PATIENT APPLICATION

Please check one of the following boxes*: ☒ I am a new patient ☐ I am re-enrolling

1 Patient Information

*= REQUIRED FIELDS

First Name* | Last Name* | Email

Date of Birth (MM/DD/YYYY)* | Sex for Clinical Use*: ☐ Male ☐ Female | Mobile Number*— *We'll keep you updated through non-marketing calls/texts.*†

Address (No PO Box)* | Home Number*— *We'll keep you updated through non-marketing calls/texts.*†

City* | State* MI | ZIP* | Household Size* | Reside in the U.S. or Territory*: ☒ Yes ☐ No

I give permission to disclose my personal health information to the following caregiver:

Caregiver Name | Relationship to Patient | Phone Number

2 Insurance Information

To prevent delays, please include copies (front and back) of **all** insurance card(s). This includes primary, secondary, and prescription insurance.

Plan Type	Plan Name	ID#	Phone#
Medicare (Red/White/Blue Card)			
Medicare Part D/Advantage			
Medicare Supplemental/Other			
Medicaid/Tricare/VA/DoD			
Private Insurance			

Employer Name (if you have insurance through an employer): _____

☐ I have no prescription drug coverage.

3 Income

Eligibility for the NPAF program requires that you provide your proof of income.
You must submit a copy of the first 2 pages of your most recent tax return (eg, 1040).*

4 Patient Authorization

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

X _____ _____

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

Complete the entire form and fax to NPAF at **1-855-817-2711** or mail to: **NPAF, PO Box 2529, Columbus, OH 43216**
An incomplete form will result in a processing delay or application denial.

Visit Website www.PAP.Novartis.com
Send Fax 1-855-817-2711
Questions? Call 1-800-277-2254
Mail to PO Box 2529 Columbus, OH 43216