FLEXCARE SPECIALTY SERVICES

Thank you for your referral for COSENTYX

REQUIRED DOCUMENTATION

Please send the following items to initiate the new prescription process:

- ☑ Manufacturer form (attached), complete with FlexCare Specialty Services identified as the preferred specialty pharmacy
- ☑ Patient Demographics
- ☑ Insurance Card
- ☑ Recent Clinicals & Labs
- ☑ Medication List
- ☑ Tried/Failed Therapies
- ☑ Negative TB Results

INSTRUCTIONS

1. Please send the completed forms to us for processing.
2. You may also send the completed forms to the manufacturer, if enrollment into the manufacturer's monitoring program is desired.

PHONE: 866-205-4239 | FAX: 855-222-2514
Email: referrals@flexcarespecialty.com | visit: flexcareinfusion.com/referrals

Cosentyx® Connect
REAL SUPPORT. PERSONAL SOLUTIONS.

START FORM

All fields REQUIRED, unless noted.

02.2022 UPDATE

FAX TO: 1-844-666-1366
Or 1-800-343-9117
PHONE: 1-844-267-3689
For Electronic Enrollment, visit: **www.CoverMyMeds.com**

1. PATIENT INFORMATION *(Section 1 to be completed and signed by Patient or Parent/Legal Guardian)* – REQUIRED

Patient's Name (First, Middle, Last) _____ DOB (MM/DD/YYYY) _____ Sex ☐ M ☐ F

Authorized Representative (First, Middle, Last) _____ Relationship to Patient _____

Address _____ City _____ State _____ ZIP _____

Cell Phone _____ ☐ OK to leave message about COSENTYX® Secondary Phone _____ ☐ OK to leave message about COSENTYX

Email (required for co-pay enrollment) _____ Preferred Language ☐ English ☐ Spanish ☐ Other _____

Patient Authorization (required)
I confirm that the information provided herein is truthful and accurate to the best of my knowledge.
☐ **I have read and agree to the Terms and Conditions for the Co-pay Assistance Program on page 3.**
The COSENTYX® Connect program includes calls and texts to help you get started on COSENTYX. After you fill your prescription, you will receive reminders, education, and lifestyle tips by mail and email. You can also get this ongoing support via calls and texts by checking the box below.
☐ **I agree to receive recurring reminders, tips, and more 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.** (Optional, please see page 3)

Novartis Patient Assistance Foundation, Inc. (NPAF) provides free medication to eligible uninsured and underinsured patients experiencing financial hardship. Proof of income is required. If you choose to apply for free medication, 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 3.** (Optional)

PATIENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____ (MM/DD/YYYY)
I have read and agree to the Patient Authorization on page 2.
CANNOT PROCESS FORM WITHOUT SIGNATURE AND DATE

2. INSURANCE INFORMATION *(Section 2 to be completed by Patient or Parent/Legal Guardian)* – REQUIRED

Please check appropriate box: ☐ Uninsured ☐ Insured If insured, please check one: ☐ Provide Information Below **Or** ☐ Copy of Primary Medical and Prescription Cards Attached (Front & Back)

Beneficiary/Cardholder Name _____ Prescription Insurance _____

Primary Health Insurance _____ Phone # _____ Rx Group # _____

Primary Health Insurance ID _____ Rx ID# _____

Group # _____ Rx BIN # _____ Rx PCN # _____

FOR HEALTHCARE PROVIDER USE ONLY

3. PRESCRIBER INFORMATION *(Sections 3–7 to be completed by the prescriber)* – REQUIRED EXCEPT WHERE NOTED

Prescriber's Name _____ Site Institution Name (optional) _____

NPI # _____ Collaborating MD/DO _____

Address _____ City _____ State _____ ZIP _____

Office Contact Name _____ Office Phone _____ Office Fax _____

Office Email (optional) _____

4. CLINICAL INFORMATION – REQUIRED

Primary Diagnosis/ICD-10-CM Codes: (check one) – REQUIRED ☐ L40.0 Plaque Psoriasis ☐ L40.5 Psoriatic Arthritis ☐ L40.54 Psoriatic juvenile arthropathy
☐ M08.90 Juvenile arthritis, unspecified ☐ M45.0 Ankylosing Spondylitis ☐ M45.A Non-Radiographic Axial Spondyloarthritis ☐ Other ICD-10-CM Code(s): _____

Secondary Diagnosis/Special Areas or Manifestations (optional) _____

Has patient participated in a COSENTYX clinical trial? ☐ Yes ☐ No The patient has previously been treated with a biologic for the diagnosed condition. ☐ Yes ☐ No

If patient has been treated with a biologic or another therapy, please answer the following questions:

Excluding COSENTYX, does this patient have a contraindication, intolerance, or allergy to Cimzia®, Enbrel®, Humira®, Remicade®, Simponi®, Stelara®, Taltz®, or other biologic treatments, or to phototherapy, methotrexate, sulfasalazine, NSAIDs (diclofenac, ibuprofen, etc)? ☐ Yes _____ ☐ No

Excluding COSENTYX, does this patient have documented efficacy failure of adequate trial on NSAIDs, DMARDs, or other treatments? ☐ Yes ☐ No

If YES, please indicate which drug(s):

☐ Cimzia® ☐ Enbrel® ☐ Humira® ☐ Otezla® ☐ Remicade® ☐ Rinvoq® ☐ Simponi® ☐ NSAIDs (diclofenac, ibuprofen, etc)
☐ Skyrizi® ☐ Stelara® ☐ Taltz® ☐ Tremfya® ☐ Phototherapy ☐ Methotrexate ☐ Sulfasalazine ☐ Other _____

5. SELECT PRESCRIPTION TYPE – REQUIRED

PLEASE CHECK PRESCRIPTION TYPE (MUST CHECK BOTH TO FILL PHARMACY AND BRIDGE RX):
☐ **PHARMACY PRESCRIPTION** ☐ **COVERED UNTIL YOU'RE COVERED FREE MEDICATION PRESCRIPTION (TERMS AND CONDITIONS APPLY*)**

SHIP TO INFORMATION FOR COVERED UNTIL YOU'RE COVERED FREE MEDICATION PRESCRIPTION – REQUIRED
FIRST DOSE, SHIP TO: ☐ Patient ☐ Office, as allowable by law **ALL SUBSEQUENT DOSES WILL BE SHIPPED TO THE PATIENT**

6. PHARMACY PRESCRIPTION – REQUIRED

Patient Weight: _____ kg / lbs **(circle one unit of measure)** **Date Weight Obtained:** _____

HCP Preferred Specialty Pharmacy (optional): FlexCare Specialty Services ☑ The patient prescription has been sent to the specialty pharmacy noted here

Adult			Dosing	Qty	Refills
COSENTYX 150 mg	☐ Sensoready® (1x150 mg/mL)	☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____
COSENTYX 300 mg	☐ Sensoready (2x150 mg/mL)	☐ Prefilled Syringe (2x150 mg/mL)	☐ **Loading Dose:** Inject 300 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 300 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____
Pediatric			**Dosing**	**Qty**	**Refills**
COSENTYX 75 mg (wt <50 kg)		☐ Prefilled Syringe (1x75 mg/mL)	☐ **Loading Dose:** Inject 75 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 75 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____
COSENTYX 150 mg (wt ≥50 kg)	☐ Sensoready (1x150 mg/mL)	☐ Prefilled Syringe (1x150 mg/mL)	☐ **Loading Dose:** Inject 150 mg subcutaneously on Weeks 0, 1, 2, 3 ☐ **Maintenance:** Inject 150 mg subcutaneously on Week 4, then every 4 weeks thereafter	28 days 28 days	ZERO ____

***COVERED UNTIL YOU'RE COVERED PROGRAM: Eligible patients must have commercial insurance, a valid prescription for COSENTYX, and a denial of insurance coverage based on prior authorization request. Program requires the submission of an appeal within 90 days after enrollment. See Program Terms and Conditions on page 3.** I understand that the Covered Until You're Covered Program is designed to support patients who are denied insurance coverage for COSENTYX for up to two years until such coverage is secured, and I confirm that I will support the above identified patient in seeking to secure such coverage as I deem appropriate. I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed COSENTYX to the previously identified patient. **I have discussed the COSENTYX® Connect 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 COSENTYX® Connect. To complete this enrollment, Novartis may contact the patient by phone, text, and/or email.** I also agree to receive communications, including faxes, related to my patient's enrollment or participation in the COSENTYX® Connect Program. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. I authorize Novartis Pharmaceuticals Corporation and its service providers, and the Novartis Patient Assistance Foundation, Inc. (NPAF) and its service providers to transmit the above prescription by any means allowed under applicable law to the appropriate specialty pharmacy for my patient. I agree to the NPAF Authorization on page 3.

CANNOT PROCESS FORM WITHOUT A SIGNATURE AND DATE

PRESCRIBER SIGNATURE _____ DATE _____
Dispense as Written (No Stamps) **(MM/DD/YYYY)**

OR

PRESCRIBER SIGNATURE _____ DATE _____
Substitution Permitted (No Stamps) **(MM/DD/YYYY)**

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

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080