FABHALTA® (iptacopan) Patient Pharmacy/Medical Claim Reimbursement Request Form

FABHALTA Co-pay Program, IQVIA Inc., Claims Processing Department, 77 Corporate Dr, Bridgewater, NJ 08807 Telephone: 1-888-665-9803 **Fax:** 908-548-9364

Please complete this form and submit with all required information and attachments to be considered for reimbursement. Subject to a combined annual limit up to $20,000 in copay benefits for the cost of FABHALTA and up to $1000 for qualifying vaccination costs. Reimbursement not available (i) for patients covered under Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care programs, (ii) where patient is not using insurance coverage at all, (iii) where patient's insurance plan reimburses for the entire cost of the drug, or (iv) where prohibited by law. Please see below for full program Terms and Conditions.

To receive reimbursement from the FABHALTA Co-pay Program, please complete the following:

1. Fill out Patient Information
2. Fill out FABHALTA Co-pay Card Information
3. Read and sign Certification Statement
4. Mail or fax this form along with the required items

PATIENT INFORMATION			
Patient Last Name:		**Patient First Name:**	
Patient Date of Birth:		**Patient ZIP Code:**	
Gender:	☐ Male ☐ Female	**Patient Paid Amount ($):**	
Co-pay Group #*:		**Patient Co-pay ID #*:**	

*Co-pay Group # and Co-pay ID # are provided to you in your FABHALTA Co-pay Program communication. Reimbursement by check only via this form.

REQUIRED INFORMATION AND ATTACHMENTS

Send this completed form, along with the items listed below, via mail or fax.


RECEIPT
ANY PHARMACY, INC
100 Main St.
Anytown, NY 12345
Rx:100053 Filled:03/31/05
SMITH, JOHN Q (CC)
123 MOTORPARK WAY
HAUPPAUGE,NY 11788 OFI
MYDRUG 120 MG
Qty:30 NDC:00000000000
No Refills
NO AUTHORIZATION REQUIRED
DR.JONES, TOM
1324 MOTOR PARKWAY, HAUPPAUGE,NY 11788
AA0000000 (631)582-4787
RxPrice:$xxx.xx
THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

✓ **If you are submitting a <u>Pharmacy</u> claim for FABHALTA or vaccine reimbursement associated with FABHALTA, you will need to provide:**

- Original pharmacy package label and receipt/invoice (see sample receipt, on right), which must include the following information:
  - Patient name and address
  - Pharmacy name, address, and phone #
  - Doctor or health care provider name, address, and phone #
  - Prescription # (Rx #), fill date, drug name, strength, National Drug Code #, and quantity
  - Overall prescription price and co-pay/out-of-pocket expense paid
  - Payment Amount and Date of Purchase
- A copy of the front and back of your prescription card

✓ **If you are submitting a <u>Medical</u> Insurance claim for FABHALTA for vaccine reimbursement associated with FABHALTA, you will need to provide:**

- Explanation of Benefits (EOB) from your insurance provider and/or CMS-1500 or CMS-1450/UB-04 form from your health care provider
- Proof of payment
- A copy of the front and back of your medical insurance card(s)

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77 Corporate Dr,
Bridgewater, NJ 08807

Please note, failure to include any of the above will result in claim rejection.

FABHALTA Co-pay Program Terms & Conditions

*Limitations apply. Offer not valid under Medicare, Medicaid, or any other federal or state programs. Patients with commercial insurance coverage for FABHALTA may receive up to $20,000 in annual co-pay benefits for the cost of FABHALTA and up to $1,000 for qualifying vaccination costs. Patients with commercial insurance and a prior authorization requirement may receive up to 12 months of free product while coverage is pursued. A prior authorization and/or appeal of coverage denial must be submitted within 90 days to remain in the program. Novartis reserves the right to rescind, revoke, or amend this program without notice. See complete Terms & Conditions at www.fabhalta.com for details.

Certification Statement

I certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by insurance, a flexible spending account (FSA), health savings account (HSA), or any other player. I certify that the patient is not covered under Medicare, Medicaid, TRICARE, VA, DoD, or any other government (state or federally funded) program and that my use of this form is not prohibited by federal or state law. I understand and agree that I am liable for any misrepresentations herein to the full extent of applicable law.

Acknowledged and agreed *(Patient signature required)*: _____ Date: _____

Please allow 4-6 weeks for processing claims. Successful claims will be processed and paid in the subsequent billing cycle.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080