

# FABHALTA (iptacopan) Patient Reimbursement Request Form

**To see if Novartis Patient Support can reimburse you for medication or treatment, please:**

1. Fill out the Patient Information section below.
2. Provide a copy of the front and back of your prescription card.
3. Sign the Certification Statement at the end of this form.
4. Mail or fax your request, receipts, and this form to:  
Novartis Patient Support Claims Processing Department  
430 Mountain Avenue, Suite 105, New Providence, NJ 07974  
Fax: 1-908-548-9364

Patient Information*			
Last Name:		First Name:	
Address 1:		Address 2:	
City:		State:	ZIP Code:
Date of Birth:		Phone Number:	
Sex for Clinical Use:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Amount Paid (\$):	
Group #:		Rx ID #:	

\*All Patient Information fields are required

## Helpful Tip

**You can find your Co-Pay Plus<sup>†</sup> Group # and Rx ID #  
in Novartis Patient Support communications**

## Supporting Materials

**If you are submitting for reimbursement for a claim from a pharmacy, please provide:**

**Original pharmacy receipt and invoice. It must include:**

- ▶ Patient name and address
- ▶ Pharmacy name, address, and phone number
- ▶ Health care provider name, address, and phone number
- ▶ Prescription number, fill date, drug name, strength, National Drug Code (NDC) number, and quantity
- ▶ Overall prescription price and co-pay amount paid
- ▶ A copy of the front and back of your prescription card

**If you are submitting for reimbursement for a claim from a health care provider/site of care, please provide:**

- ▶ Explanation of Benefits (EOB) from your insurance provider and CMS-1500, UB-92 or CMS-1450/UB-04 form from your health care provider
- ▶ Proof of payment
- ▶ A copy of the front and back of your insurance card(s)

Last Name:		First Name:	
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**Mail or fax this completed form and supporting materials to:**

Novartis Patient Support Claims Processing Department  
430 Mountain Avenue, Suite 105, New Providence, NJ 07974  
**Fax: 1-908-548-9364**

**Questions? Your Novartis Patient Support team can help. Call 1-833-993-2242**

**Don't Forget!**

**If you don't include all the required information, your claim will be rejected**

**Co-Pay Plus Terms & Conditions**

**\*Limitations apply.** Patients with private 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 (excluding administrative fees). Patient is responsible for any costs once the 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. 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, Puerto Rico, and select territories. Void where prohibited by law. Additional restrictions may apply. 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 this Program and discontinue support at any time without notice.

**Patient 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 payer. I certify that I am 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/caregiver signature required): \_\_\_\_\_ Date: \_\_\_\_\_

Please allow 7-10 business days for processing and payment of claims.

