Sandostatin® LAR Depot
(octreotide acetate for injectable suspension)
10mg • 20mg • 30mg

Sandostatin® LAR Depot (octreotide acetate for injectable suspension)
Co-Pay Assistance Program Application

For patient's who receive their Sandostatin LAR Depot in the physisican's office, complete steps 1-4 and fax to 1-888-891-4924

For questions, call 1-800-282-7630

With the Sandostatin® LAR Depot Co-Pay Assistance Program, eligible patients pay a $25 maximum co-pay for their Sandostatin LAR Depot prescriptions. Novartis Pharmaceuticals Corporation will pay the remainder of the co-pay for Sandostatin LAR Depot:

- **For commercial patients, up to $9600 per calendar year**
- **For cash patients, up to $800 per injection and $9600 per calendar year**

PATIENTS ARE ELIGIBLE IF THEY

- Are at least 18 years of age
- Have been prescribed, and receive, an approved dose of Sandostatin LAR Depot for an approved indication
- Live in the United States or Puerto Rico
- Have commercial insurance with medical and/or prescription benefits that cover Sandostatin LAR Depot, or are paying in full for their Sandostatin LAR Depot
- Are not on Medicare, Medicaid, or other coverage under any federal or state health care program

STEP 1 | Complete Patient and Insurance Information

(Please include copies of the front and back of your patient's insurance cards)

First name _____ Last name _____

Address _____

City _____ State _____ ZIP _____

Home phone _____ Best time to call _____ AM/PM

Cell phone _____ E-mail address _____

Language preference _____ Sex ☐M ☐F Date of Birth: _____ (MM/DD/YYYY)

Ok to call cell phone? ☐Y ☐N (Standard carrier rates may apply)

Do you have prescription drug coverage? ☐Y ☐N

Are you enrolled in Medicare Part D? ☐Y ☐N

If no, will you be paying for your medication privately? ☐Y ☐N

Primary diagnosis ICD-9-CM code: _____

Primary insurance name _____

Beneficiary/Cardholder name _____ ID # _____

Group # _____ Phone _____

Secondary insurance _____

Beneficiary/Cardholder name _____ ID # _____

Group # _____ Phone _____

Prescription insurance (Medicare patients please use Medicare Part D information) _____

Group # _____ Phone _____

Pharmacy services phone (see back of card) _____

New to therapy? ☐Y ☐N

STEP 2 | Complete Prescriber Information

First name _____ Last name _____ Suffix _____

Site name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

E-mail address _____

Specialty _____ DEA # _____

Tax ID # _____

NPI # _____

Office contact _____ Office contact phone _____

STEP 3 | Read and Sign Physician Authoriza-

I have read and agree to the Physician Authorization **Section A** on page 2 of this document. *(Signature required)*

X _____ _____

Prescriber signature (MM/DD/YYYY)

STEP 4 | Read and Sign Patient Authorization

I have read and agree to the Patient Authorization **Section B** on page 2 of this document. *(Signature required)*

X _____ _____

Patient/Legal guardian signature (MM/DD/YYYY)

I have read and agree to the Patient Authorization **Section 2B** on page 2 of this document. *(Signature required)*

X _____ _____

Patient/Legal guardian signature (MM/DD/YYYY)

For internal use only

Case Number: _____ Eligibility begins: ____ / ____ / _____

NOVARTIS ONCOLOGY

A → Physician Authorization

I authorize Novartis Pharmaceuticals Corporation, its affiliates, business partners and agents (together, the "Novartis Group") to use and disclose the patient's health information and information relating to the patient's insurance coverage so that the Novartis Group can (i) verify the patient's insurance coverage or coordinate insurance coverage or otherwise obtain payment for the patient's treatment with a Novartis Oncology product indicated on page 1, and (ii) provide information about the patient's insurance coverage to other health care providers who are involved in the patient's treatment with a Novartis Oncology product indicated on page 1. I certify that I have provided the patient with materials that describe Sandostatin co-pay assistance program.

B → Patient Authorization

I authorize my doctor(s) and their staff, my employer, and my health insurer(s) to disclose my personal information, including information about my insurance, prescriptions, medical condition and health ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates, business partners, and agents (together, the "Novartis Group") so that the Novartis Group can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with a Novartis Oncology product, (ii) coordinate my receipt of, and payment for, a Novartis Oncology product indicated on page 1, and Sandostatin co-pay assistance program, and (iii) conduct market research, quality assurance, and other internal business activities.

2B → I authorize the Novartis Group to disclose my Personal Information to any pharmacies, insurance carriers, health care providers (including my doctor(s) and their staff) and other third parties for the purposes described above. I understand that these other parties may report back to the Novartis Group any Personal Information about me that they may create or receive and that Novartis Group may disclose such Personal Information to my doctor(s) and their staff. I authorize the Novartis Group to contact me directly for the purposes described above. I agree to receive phone calls and materials from the Novartis Group at the number and address listed on page 1 of this form. I understand that once my health information is disclosed it may no longer be protected by federal or state law regarding patient privacy and that neither my doctor(s), my employer, nor my health insurer can guarantee that it will not be re-disclosed to a third party. I understand that I may refuse to sign this authorization or revoke it at any time in the future, and my refusal or future revocation will not affect the commencement, continuation, or quality of my treatment by my doctor(s). However, I understand that if I revoke this authorization, I may no longer be eligible to participate in the Program. I understand that this authorization will remain valid for 5 years after the date of my signature, unless I revoke it earlier by calling 1-800-282-7630. I also understand that the Program may be changed or terminated at any time without prior notification. I understand that I may receive a copy of this authorization.