



P. O. Box 66556
St. Louis, MO 63166-6556

Dear Patient or Health Care Provider:

Thank you for your interest in the Novartis Patient Assistance Program (PAP). To be eligible for the Novartis PAP, patients must be a U.S. resident, meet the income requirements, and must not have prescription drug coverage. Please complete the following steps to apply for the Novartis PAP.

- 1.) Complete all patient and physician sections of the attached application.
- 2.) Attach an original prescription for the requested medication (except Retail Card products).
- 3.) Attach a copy of your most recent year federal tax return or financial documentation.

Some examples include:

- IRS Form 1040, 1040EZ
- Paycheck stubs
- 1099 Social Security Statement
- W-2 Forms

- 4.) Mail the Application, Prescription, and Financial Documentation to:

NOVARTIS PATIENT ASSISTANCE PROGRAM
PO BOX 66556
ST. LOUIS, MO 63166-6556

We will review and process the patient's eligibility once we receive the completed application, prescription and supporting financial documentation. You will receive written notification concerning the patient's eligibility.

The following products are offered on the Novartis Patient Assistance Program.

Comtan®
(entacapone)

Diovan®/Diovan HCT®
(valsartan)

Elidel®*
(pimecrolimus)

Enablex®
(darifenacin)

Exelon®
(rivastigmine tartrate)

Eyescrub®**

Famvir®
(famciclovir)

Focalin™ (Retail Card)
(dexamethylphenidate HCl)

Focalin™ XR (Retail Card)
(dexamethylphenidate HCl extended release)

GenTeal®**

GenTeal®**
Severe Lubricant Eye Gel
Hypotears®**

Lamisil®
(terbinafine HCL tablets)

Lescol®/Lescol® XL
(fluvastatin sodium)

Lotrel®
(amlodipine besylate/benazepril HCl)

Miacalcin®*
(calcitonin-salmon)

Ritalin® LA (Retail Card)
(methylphenidate HCl)

Sandostatin LAR®
(octerotide acetate)

Stalevo®
(carbidopa, levodopa and entacapone)

Starlix®
(nateglinide)

Tegretol®
(carbamazepine USP)

Tegretol-XR®
(carbamazepine extended release)

Trileptal®
(oxcarbazepine)

Voltaren Ophthalmic®**
(diclofenac sodium ophthalmic solution)

Zaditor®**

Zelnorm™
(tegaserod maleate)

For any other Novartis Pharmaceuticals product not listed, please call 1-800-277-2254.

The majority of products are dispensed in 90-day supplies. All products will be shipped directly to the physician's office (except for Retail Card products***).

If you have any questions, please call a Novartis Patient Assistance Program representative at 1-800-277-2254, Monday through Friday, 9:00 am to 6:00 pm EST.

Sincerely,

Novartis Patient Assistance Program

*Medications are dispensed in 30-day supplies

**Medications are dispensed in 180-day supplies.

***In the case of Retail Card products such as Focalin/Focalin XR and Ritalin LA, a pharmacy card will be sent to the patient. The patient must take the pharmacy card and a valid prescription to their retail pharmacy to receive the product.

**Novartis Pharmaceuticals Corporation
Patient Assistance Program Enrollment Application**

IMPORTANT: A VALID PRESCRIPTION AND PATIENT FINANCIAL DOCUMENTATION MUST BE ATTACHED TO PROCESS THIS APPLICATION.

PATIENT INFORMATION			
Patient Name:		SSN/ID No:	
Address:		Date of Birth:	
City:	State:	Zip:	
Phone Number: ()		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Number of people in household (including self)? Circle One: 1 2 3 4 5 6 or more			
US Resident <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a Veteran of the US Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MEDICATION INFORMATION			
<input type="checkbox"/> *Focalin™ (dexmethylphenidate HCl) <input type="checkbox"/> *Focalin™ XR (dexmethylphenidate HCl extended release) <input type="checkbox"/> *Ritalin® LA (methylphenidate HCl) *Patient must bring the issued retail pharmacy card, along with the prescription, to the pharmacy.		<input type="checkbox"/> Other - Please specify requested product(s): _____ * Please attach a valid prescription.	
FINANCIAL INFORMATION- Attach a copy of your most recent federal tax return or other supporting financial documentation. Income examples: 1040, 1040EZ, 1040X, 1099			
List all sources, Gross Monthly Amounts			
Salary/Wages \$ _____	Social Security \$ _____		
Disability \$ _____	Pension/Retirement \$ _____		
Alimony/Child Support \$ _____	Unemployment/Work Comp \$ _____		
Total Gross Household Monthly Income: \$ _____		ATTACH PROOF OF INCOME	
Total Patient Household Assets (excludes first home and car): \$ _____			
INSURANCE INFORMATION			
Private Prescription Drug Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No (if Yes, please check all that apply)	Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D <input type="checkbox"/>	Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No
I know that all the information I provide in applying will be used to decide if I can participate in the Novartis PAP. By signing below I verify that the information on this application, including the signed copy of my prior year's tax return/supporting documentation, is complete and accurate. I also verify that I have no other coverage for prescription medications, including Medicaid, Medicare or any public or private assistance programs or any other prescription insurance. I also agree that Novartis or its third party agents have the right to verify my eligibility, including an audit of reported financial and insurance information and medical records. I understand that Novartis or its third party agents have the right to contact me directly to confirm receipt of medications, and to revise, change, or terminate this program at any time. All information that I provide may be utilized by Novartis or any third-party agent working on behalf of Novartis in connection with the PAP. I authorize any agent of Novartis who is administering the PAP, to disclose to Novartis (or any other agent of Novartis working in relation to the PAP), my personal information, including, my medical condition, treatment and insurance coverage. I understand that if I refuse to sign this authorization, I will not be able to participate in the PAP, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance benefit. Further, I understand that if I cancel my authorization as described below, I will no longer be eligible for the PAP. I can revoke this authorization at any time.			
Signature of Patient or Legal guardian (<i>Required to process application</i>) X		Date	
PHYSICIAN INFORMATION – All product will be shipped to the physician's office.			
Physician Name:		DEA/State License No:	
Address:			
City:	State:	Zip:	
Phone: ()		Fax: ()	
My signature below certifies that the person named on this form is my patient and medications received from Novartis for patient assistance are only for the use of the patient named on this form. These medications will not be offered for sale, trade, or barter. Additionally, no claim for reimbursement will be submitted concerning these medications to Medicare, Medicaid, or any third party, nor returned for credit. By signing, I also agree that Novartis, or its third party agents, has the right to contact my patient directly to confirm receipt of medications, and to revise, change, or terminate this program at any time. Finally, to the best of my knowledge, my patient meets Novartis' criteria for the Patient Assistance Program.			
Signature of Physician (<i>Required to process application</i>) X		Date	

PLEASE CALL 1-800-277-2254 WITH ANY QUESTIONS