Novartis
Patient Support™

Guide to completing the FABHALTA® (iptacopan) Start Form


Not an actual patient.

Phone:
833-99FABHA (833-993-2242)

Fax:
877-44FABHA (877-443-2242)

Online:
www.fabhalta-startform.com

Portal:
www.covermymeds.health

For questions or support, reach out to your dedicated Novartis Access & Reimbursement team or contact Novartis Patient Support.

Please see Important Safety Information on pages 5-8 and full Prescribing Information, including Boxed WARNING and Medication Guide.

FABHALTA® (iptacopan) 200 mg capsules

Novartis
Patient Support

Getting patients started

Novartis Patient Support will work with your practice to help your patient start on FABHALTA. Begin the process by completing the Start Form. We have outlined the key information below to help ensure a smoother process for your office and your patient.

All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

Look for this symbol * as you fill out the Start Form. It indicates a required field.

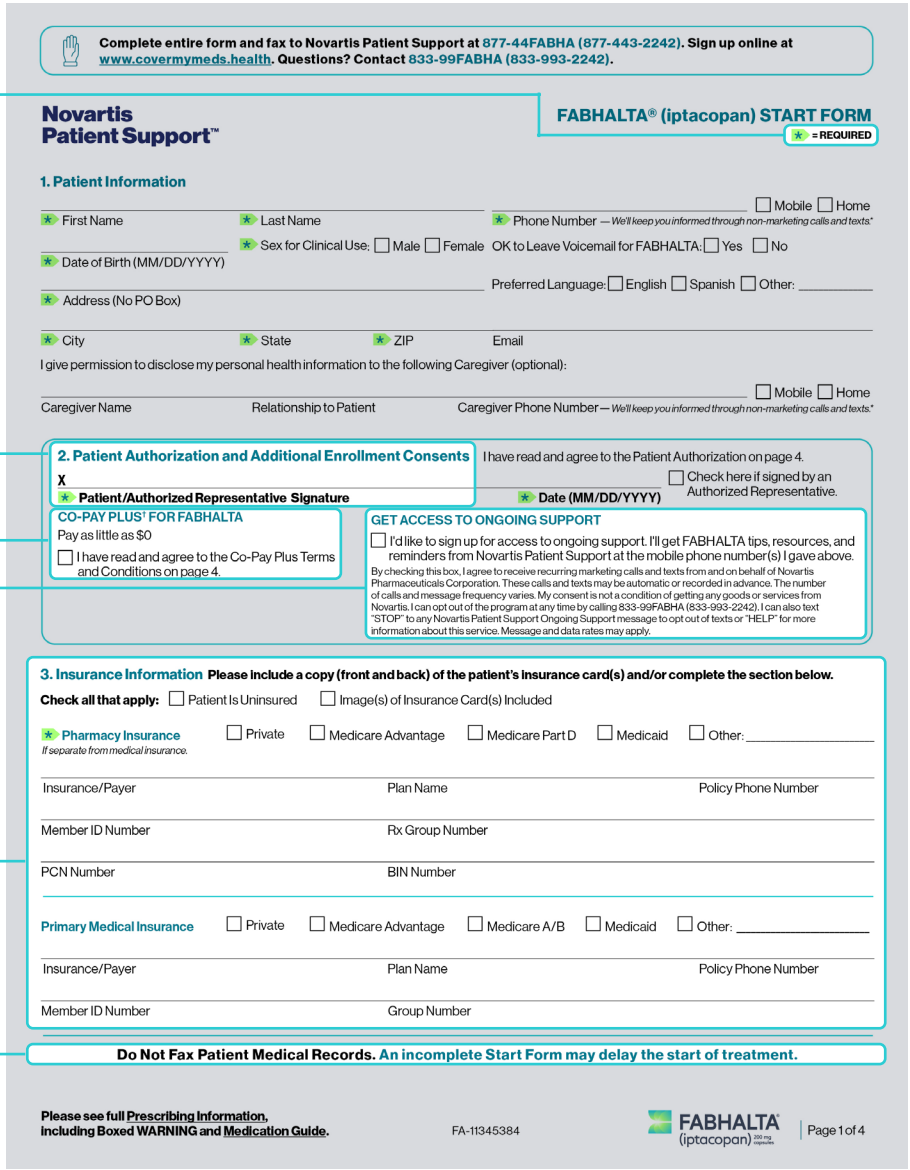
Get patient and/or authorized representative consent.

Patients can check this box to sign up for the Co-Pay Plus offer.

Patients can check this box to opt into ongoing support.

Don't forget your patient's insurance information. We need to verify all their benefits.

Please **do not fax patient medical records**.



Page 1

Complete entire form and fax to Novartis Patient Support at 877-44FABHA (877-443-2242). Sign up online at www.covermymeds.health. Questions? Contact 833-99FABHA (833-993-2242).

Novartis Patient Support™

FABHALTA® (iptacopan) START FORM

* = REQUIRED

1. Patient Information

* First Name | * Last Name | * Phone Number — *We'll keep you informed through non-marketing calls and texts.** ☐ Mobile ☐ Home

* Date of Birth (MM/DD/YYYY) | * Sex for Clinical Use: ☐ Male ☐ Female | OK to Leave Voicemail for FABHALTA: ☐ Yes ☐ No

* Address (No PO Box) | Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

* City | * State | * ZIP | Email

I give permission to disclose my personal health information to the following Caregiver (optional):

Caregiver Name | Relationship to Patient | Caregiver Phone Number — *We'll keep you informed through non-marketing calls and texts.* ☐ Mobile ☐ Home

2. Patient Authorization and Additional Enrollment Consents

I have read and agree to the Patient Authorization on page 4.

X _____ * Patient/Authorized Representative Signature | * Date (MM/DD/YYYY) | ☐ Check here if signed by an Authorized Representative.

CO-PAY PLUS† FOR FABHALTA

Pay as little as $0

☐ I have read and agree to the Co-Pay Plus Terms and Conditions on page 4.

GET ACCESS TO ONGOING SUPPORT

☐ I'd like to sign up for access to ongoing support. I'll get FABHALTA tips, resources, and reminders from Novartis Patient Support at the mobile phone number(s) I gave above.

By checking this box, I agree to receive recurring marketing calls and texts from and on behalf of Novartis Pharmaceuticals Corporation. These calls and texts may be automatic or recorded in advance. The number of calls and message frequency varies. My consent is not a condition of getting any goods or services from Novartis. I can opt out of the program at any time by calling 833-99FABHA (833-993-2242). I can also text "STOP" to any Novartis Patient Support Ongoing Support message to opt out of texts or "HELP" for more information about this service. Message and data rates may apply.

3. Insurance Information **Please include a copy (front and back) of the patient's insurance card(s) and/or complete the section below.**

Check all that apply: ☐ Patient Is Uninsured ☐ Image(s) of Insurance Card(s) Included

* **Pharmacy Insurance** *If separate from medical insurance.* ☐ Private ☐ Medicare Advantage ☐ Medicare Part D ☐ Medicaid ☐ Other: _____

Insurance/Payer | Plan Name | Policy Phone Number

Member ID Number | Rx Group Number

PCN Number | BIN Number

Primary Medical Insurance ☐ Private ☐ Medicare Advantage ☐ Medicare A/B ☐ Medicaid ☐ Other: _____

Insurance/Payer | Plan Name | Policy Phone Number

Member ID Number | Group Number

Do Not Fax Patient Medical Records. An incomplete Start Form may delay the start of treatment.

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

FA-11345384

FABHALTA® (iptacopan) 200 mg capsules | Page 1 of 4

Please see Important Safety Information on pages 5-8 and full Prescribing Information, including Boxed WARNING and Medication Guide.

FABHALTA® (iptacopan) 200 mg capsules

Novartis Patient Support

Getting patients started (cont)

All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

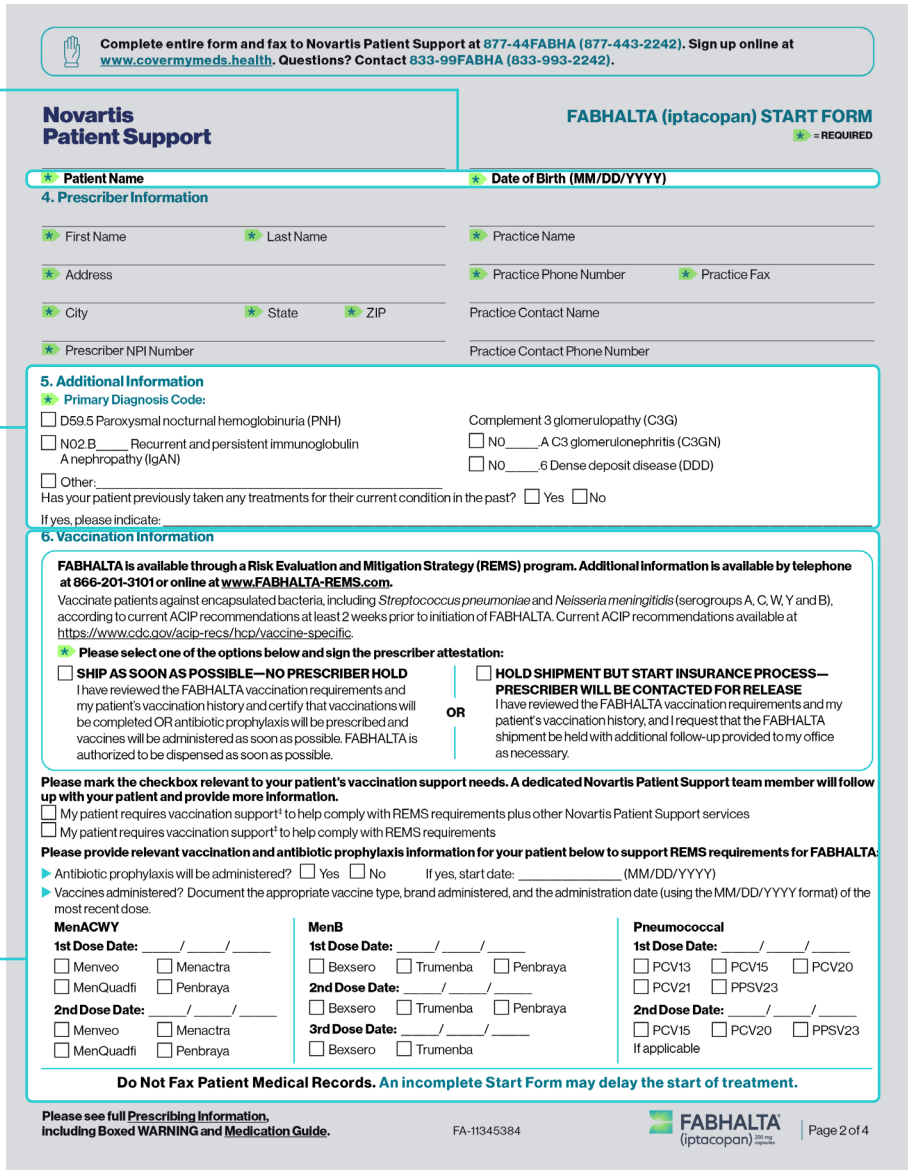
Make sure your patient's name and date of birth are present at the top of page 2.

It's important to review and capture all necessary information prior to initiating therapy:

- Indicate the applicable primary diagnosis code(s) for your patient here
  - -Multiple codes may apply for certain diagnosis codes. Reference the ICD-10 flashcard to help identify the correct one
  - -Fill in the appropriate code next to the checkbox labeled N0__.

- Make sure to check 1 of 2 checkboxes in the Vaccination section 6 on page 2 for the REMS requirement: ship as soon as possible or hold shipment
- Ensure the applicable box is checked for your patient's vaccination support needs in section 6
- Check that antibiotic prophylaxis administration is captured
- Document the appropriate vaccine type, brand, and administration date of the most recent dose for any vaccines already administered to your patient

Page 2



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Novartis Patient Support

FABHALTA (iptacopan) START FORM

★ = REQUIRED

★ Patient Name | ★ Date of Birth (MM/DD/YYYY)

4. Prescriber Information

★ First Name | ★ Last Name | ★ Practice Name

★ Address | ★ Practice Phone Number | ★ Practice Fax

★ City | ★ State | ★ ZIP | Practice Contact Name

★ Prescriber NPI Number | Practice Contact Phone Number

5. Additional Information

★ Primary Diagnosis Code:

☐ D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)

☐ N02.B____ Recurrent and persistent immunoglobulin A nephropathy (IgAN)

☐ Other:_____

Complement 3 glomerulopathy (C3G)

☐ N0_____.A C3 glomerulonephritis (C3GN)

☐ N0_____.6 Dense deposit disease (DDD)

Has your patient previously taken any treatments for their current condition in the past? ☐ Yes ☐ No

If yes, please indicate:_____

6. Vaccination Information

FABHALTA is available through a Risk Evaluation and Mitigation Strategy (REMS) program. Additional information is available by telephone at 866-201-3101 or online at www.FABHALTA-REMS.com.

Vaccinate patients against encapsulated bacteria, including *Streptococcus pneumoniae* and *Neisseria meningitidis* (serogroups A, C, W, Y and B), according to current ACIP recommendations at least 2 weeks prior to initiation of FABHALTA. Current ACIP recommendations available at https://www.cdc.gov/acip-recs/hcp/vaccine-specific.

★ **Please select one of the options below and sign the prescriber attestation:**

☐ **SHIP AS SOON AS POSSIBLE—NO PRESCRIBER HOLD**
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history and certify that vaccinations will be completed OR antibiotic prophylaxis will be prescribed and vaccines will be administered as soon as possible. FABHALTA is authorized to be dispensed as soon as possible.

OR

☐ **HOLD SHIPMENT BUT START INSURANCE PROCESS—PRESCRIBER WILL BE CONTACTED FOR RELEASE**
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history, and I request that the FABHALTA shipment be held with additional follow-up provided to my office as necessary.

Please mark the checkbox relevant to your patient's vaccination support needs. A dedicated Novartis Patient Support team member will follow up with your patient and provide more information.

☐ My patient requires vaccination support‡ to help comply with REMS requirements plus other Novartis Patient Support services

☐ My patient requires vaccination support‡ to help comply with REMS requirements

Please provide relevant vaccination and antibiotic prophylaxis information for your patient below to support REMS requirements for FABHALTA:

▶ Antibiotic prophylaxis will be administered? ☐ Yes ☐ No If yes, start date: _____ (MM/DD/YYYY)

▶ Vaccines administered? Document the appropriate vaccine type, brand administered, and the administration date (using the MM/DD/YYYY format) of the most recent dose.

MenACWY
1st Dose Date: ____/____/____
☐ Menveo ☐ Menactra
☐ MenQuadfi ☐ Penbraya
2nd Dose Date: ____/____/____
☐ Menveo ☐ Menactra
☐ MenQuadfi ☐ Penbraya

MenB
1st Dose Date: ____/____/____
☐ Bexsero ☐ Trumenba ☐ Penbraya
2nd Dose Date: ____/____/____
☐ Bexsero ☐ Trumenba ☐ Penbraya
3rd Dose Date: ____/____/____
☐ Bexsero ☐ Trumenba

Pneumococcal
1st Dose Date: ____/____/____
☐ PCV13 ☐ PCV15 ☐ PCV20
☐ PCV21 ☐ PPSV23
2nd Dose Date: ____/____/____
☐ PCV15 ☐ PCV20 ☐ PPSV23
If applicable

Do Not Fax Patient Medical Records. An incomplete Start Form may delay the start of treatment.

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FA-11345384

FABHALTA (iptacopan) 200 mg capsules | Page 2 of 4

Please see Important Safety Information on pages 5-8 and full Prescribing Information, including Boxed WARNING and Medication Guide.

FABHALTA® (iptacopan) 200 mg capsules

Novartis
Patient Support

Getting patients started (cont)

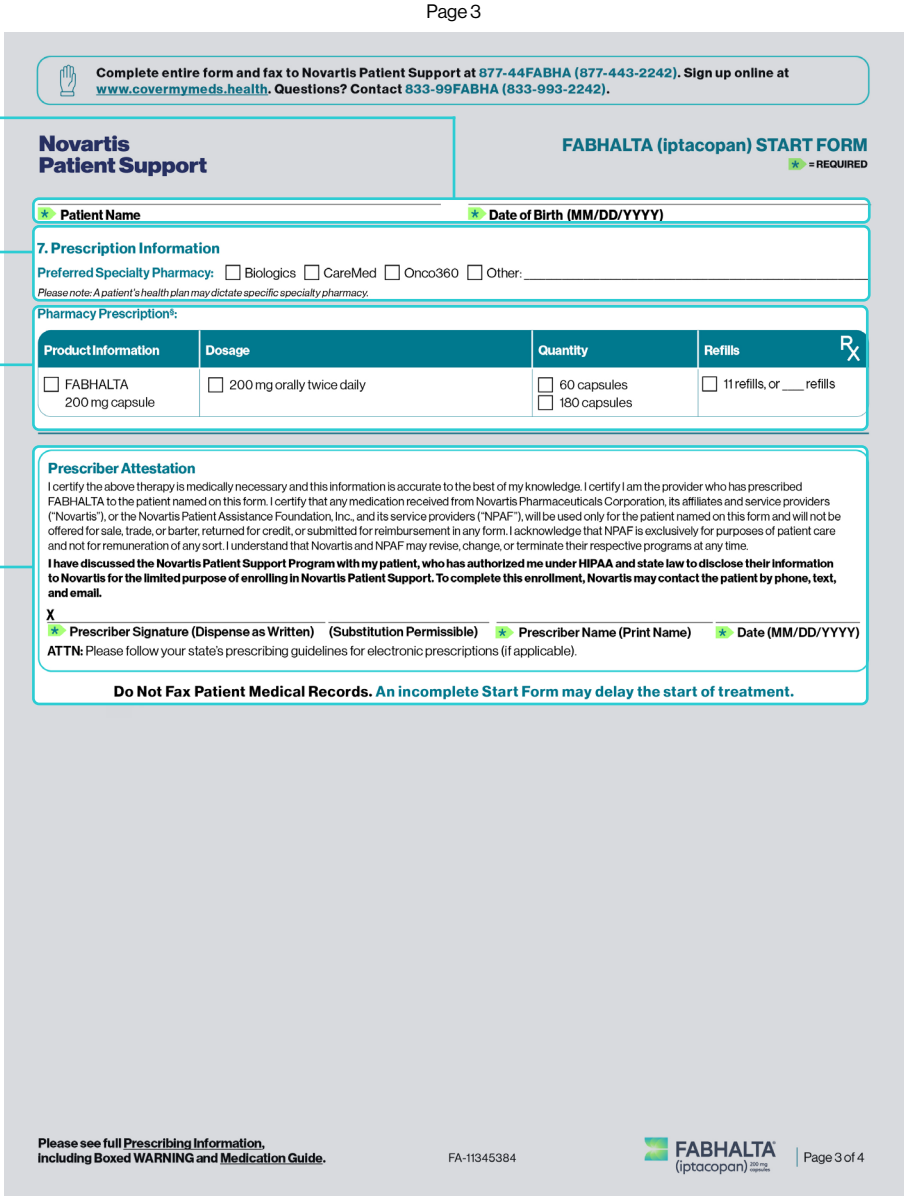
All REQUIRED fields must be filled out for the Start Form to be processed as complete. An incomplete Start Form may delay the start of treatment.

Make sure your patient's name and date of birth are present at the top of page 3.

Indicate your patient's Preferred Specialty Pharmacy.

Complete the Pharmacy Prescription table.

Please don't forget to sign and date the provider attestation.



Page 3

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Novartis Patient Support

FABHALTA (iptacopan) START FORM

★ = REQUIRED

★ Patient Name ★ Date of Birth (MM/DD/YYYY)

7. Prescription Information

Preferred Specialty Pharmacy: ☐ Biologics ☐ CareMed ☐ Onco360 ☐ Other: _____

Please note: A patient's health plan may dictate specific specialty pharmacy.

Pharmacy Prescription[5]:

Product Information	Dosage	Quantity	Refills ℞
☐ FABHALTA 200 mg capsule	☐ 200 mg orally twice daily	☐ 60 capsules ☐ 180 capsules	☐ 11 refills, or ___ refills

Prescriber Attestation

I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the provider who has prescribed FABHALTA to the patient named on this form. I certify that any medication received from Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis"), or the Novartis Patient Assistance Foundation, Inc., and its service providers ("NPAF"), will be used only for the patient named on this form and will not be offered for sale, trade, or barter, returned for credit, or submitted for reimbursement in any form. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Novartis and NPAF may revise, change, or terminate their respective programs at any time.

I have discussed the Novartis Patient Support 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 Novartis Patient Support. To complete this enrollment, Novartis may contact the patient by phone, text, and email.

X _____

★ Prescriber Signature (Dispense as Written) (Substitution Permissible) ★ Prescriber Name (Print Name) ★ Date (MM/DD/YYYY)

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

Do Not Fax Patient Medical Records. An incomplete Start Form may delay the start of treatment.

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

FA-11345384

FABHALTA (iptacopan) 200 mg capsules | Page 3 of 4

Please see Important Safety Information on pages 5-8 and full Prescribing Information, including Boxed WARNING and Medication Guide.

FABHALTA® (iptacopan) 200 mg capsules

Novartis
Patient Support

INDICATIONS AND IMPORTANT SAFETY INFORMATION

INDICATIONS

FABHALTA is indicated for:

- The treatment of adults with paroxysmal nocturnal hemoglobinuria (PNH).
- The reduction of proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥1.5 g/g.

  This indication is approved under accelerated approval based on reduction of proteinuria. It has not been established whether FABHALTA slows kidney function decline in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.
- The treatment of adults with complement 3 glomerulopathy (C3G), to reduce proteinuria.

IMPORTANT SAFETY INFORMATION

WARNING: SERIOUS INFECTIONS CAUSED BY ENCAPSULATED BACTERIA

FABHALTA, a complement inhibitor, increases the risk of serious infections, especially those caused by encapsulated bacteria, such as *Streptococcus pneumoniae*, *Neisseria meningitidis*, and *Haemophilus influenzae* type b. Life-threatening and fatal infections with encapsulated bacteria have occurred in patients treated with complement inhibitors. These infections may become rapidly life-threatening or fatal if not recognized and treated early.

- **Complete or update vaccinations for encapsulated bacteria at least 2 weeks prior to the first dose of FABHALTA, unless the risks of delaying therapy with FABHALTA outweigh the risk of developing a serious infection. Comply with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against encapsulated bacteria in patients receiving a complement inhibitor.**
- **Patients receiving FABHALTA are at increased risk for invasive disease caused by encapsulated bacteria, even if they develop antibodies following vaccination. Monitor patients for early signs and symptoms of serious infections and evaluate immediately if infection is suspected.**

Because of the risk of serious infections caused by encapsulated bacteria, FABHALTA is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the FABHALTA REMS.

CONTRAINDICATIONS

- In patients with serious hypersensitivity to FABHALTA or any of the excipients.
- For initiation in patients with unresolved serious infection caused by encapsulated bacteria, including *Streptococcus pneumoniae*, *Neisseria meningitidis*, or *Haemophilus influenzae* type b.

Please see additional Important Safety Information on the following pages and full Prescribing Information, including Boxed WARNING and Medication Guide.

FABHALTA® (iptacopan) 200 mg capsules

IMPORTANT SAFETY INFORMATION (CONTINUED)

WARNINGS AND PRECAUTIONS

Serious Infections Caused by Encapsulated Bacteria

- FABHALTA, a complement inhibitor, increases a patient's susceptibility to serious, life-threatening, or fatal infections caused by encapsulated bacteria, including *Streptococcus pneumoniae*, *Neisseria meningitidis* (caused by any serogroup, including nongroupable strains), and *Haemophilus influenzae* type b. Life-threatening and fatal infections with encapsulated bacteria have occurred in both vaccinated and unvaccinated patients treated with complement inhibitors. The initiation of FABHALTA is contraindicated in patients with unresolved serious infections caused by encapsulated bacteria.
- Complete or update vaccination against encapsulated bacteria at least 2 weeks prior to the start of FABHALTA, according to the current ACIP recommendations for patients receiving a complement inhibitor. Revaccinate patients in accordance with ACIP recommendations considering the duration of therapy with FABHALTA. Note that ACIP recommends an administration schedule in patients receiving complement inhibitors that differs from the administration schedule in the vaccine prescribing information. If urgent FABHALTA therapy is indicated in a patient who is not up-to-date with vaccinations against encapsulated bacteria according to ACIP recommendations, provide the patient with antibacterial drug prophylaxis and administer these vaccines as soon as possible. The benefits and risks of treatment with FABHALTA, as well as the benefits and risks of antibacterial drug prophylaxis in unvaccinated or vaccinated patients, must be considered against the known risks for serious infections caused by encapsulated bacteria.
- Vaccination does not eliminate the risk of serious encapsulated bacterial infections, despite development of antibodies following vaccination. Closely monitor patients for early signs and symptoms of serious infection and evaluate patients immediately if an infection is suspected. Inform patients of these signs and symptoms and instruct patients to seek immediate medical care if they occur. Promptly treat known infections. Serious infection may become rapidly life-threatening or fatal if not recognized and treated early. Consider interruption of FABHALTA in patients who are undergoing treatment for serious infections, depending on the risks of interrupting treatment in the disease being treated.

FABHALTA REMS

- FABHALTA is available only through a restricted program under a REMS called FABHALTA REMS because of the risk of serious infections caused by encapsulated bacteria.
- Under the FABHALTA REMS, prescribers must enroll in the program; counsel patients about the risks, signs, and symptoms of serious infections caused by encapsulated bacteria; provide patients with the REMS educational materials; ensure patients are vaccinated against encapsulated bacteria; prescribe antibacterial drug prophylaxis if patients' vaccination status is not up-to-date and treatment must be started urgently; and provide instructions to always carry the Patient Safety Card during treatment and for 2 weeks following the last dose of FABHALTA.
- Further information is available by telephone: 1-833-993-2242 or online at www.FABHALTA-REMS.com.

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

FABHALTA® (iptacopan) 200 mg capsules

IMPORTANT SAFETY INFORMATION (CONTINUED)

Monitoring of PNH Manifestations After FABHALTA Discontinuation

- In PNH patients, after discontinuing FABHALTA, closely monitor patients for at least 2 weeks after the last dose for signs and symptoms of hemolysis. These signs include elevated lactate dehydrogenase (LDH) levels along with a sudden decrease in hemoglobin or PNH clone size, fatigue, hemoglobinuria, abdominal pain, dyspnea, major adverse vascular events (such as thrombosis, stroke, and myocardial infarction), dysphagia, or erectile dysfunction. If discontinuation of FABHALTA is necessary, consider alternative therapy.
- If hemolysis occurs after discontinuation of FABHALTA, consider restarting treatment with FABHALTA, if appropriate, or initiating another treatment for PNH.

Hyperlipidemia

- FABHALTA may increase total cholesterol, LDL cholesterol, and serum triglycerides.
- Of the 88 FABHALTA-treated patients in PNH clinical trials who had normal total cholesterol at baseline, 31 patients developed grade 1 hypercholesterolemia during the randomized or core treatment period, and 1 patient worsened from grade 1 at baseline to grade 2.
- Of the 96 FABHALTA-treated patients in PNH clinical trials with LDL cholesterol ≤130 mg/dL at baseline during the randomized or core treatment period, 14 patients developed LDL cholesterol >130-160 mg/dL, 6 patients developed LDL cholesterol >160-190 mg/dL, and 4 patients developed LDL cholesterol >190 mg/dL.
- Of the 89 FABHALTA-treated patients in PNH clinical trials with normal triglycerides during the randomized or core treatment period, 22 patients developed grade 1 elevated triglycerides. Three patients experienced an increase in triglycerides from grade 1 to grade 2.
- Of the 102 FABHALTA-treated patients in PNH clinical trials, 2 patients required cholesterol-lowering medications.
- Monitor serum lipid parameters periodically during treatment with FABHALTA and initiate cholesterol-lowering medications, if indicated.

ADVERSE REACTIONS

- The most common adverse reactions (≥10%) in adults with PNH receiving FABHALTA were headache, nasopharyngitis, diarrhea, abdominal pain, bacterial infection, viral infection, nausea, and rash.
- The most common adverse reactions (≥5%) in adults with IgAN receiving FABHALTA were upper respiratory tract infection, lipid disorder, and abdominal pain.
- The most common adverse reactions (≥10%) in adults with C3G receiving FABHALTA were nasopharyngitis and viral infection.

DRUG INTERACTIONS

- Concomitant use of CYP2C8 inducers (eg, rifampin) may decrease iptacopan exposure, which may result in loss of or reduced efficacy of FABHALTA. Monitor the clinical response and discontinue use of the CYP2C8 inducer if loss of efficacy of FABHALTA is evident.
- Concomitant use of strong CYP2C8 inhibitors (eg, gemfibrozil) may increase iptacopan exposure, which may result in an increased risk for adverse reactions with FABHALTA. Coadministration with a strong CYP2C8 inhibitor is not recommended.

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

FABHALTA® (iptacopan) 200 mg capsules

IMPORTANT SAFETY INFORMATION (CONTINUED)

USE IN SPECIFIC POPULATIONS

- Because of the potential for serious adverse reactions in a breastfed child, breastfeeding should be discontinued during treatment and for 5 days after the final dose.
- FABHALTA is not recommended in patients with severe hepatic impairment (Child-Pugh class C). No dose adjustment is required for patients with mild (Child-Pugh class A) or moderate (Child-Pugh class B) hepatic impairment.

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

Novartis Patient Support

Your patients are our top priority

Novartis Patient Support is a comprehensive program that is designed to help your eligible patients start, stay, and save on FABHALTA.

Not an actual patient.

We support you and your patient's journey with:

- Dedicated assistance with access and reimbursement
- Personalized support for your patients on therapy
- Single points of contact for you and your patients

Our offerings include:

Insurance Support

Help navigating the insurance process, including benefits verification and support with the prior authorization and appeals processes.

Financial Support

Assistance with relevant savings options for your eligible patients, including $0 Co-Pay Plus* offer and affordability programs.

Vaccination Support†

Our dedicated Novartis Patient Support team offers support to help your patients locate vaccinations.

Ongoing Support

Dedicated assistance from our team and educational resources to help your patients get started on treatment and guide them along the way.

Questions?

For more information, call Novartis Patient Support at 833-99FABHA (833-993-2242), Monday-Friday, 8:00 AM-8:00 PM ET, excluding holidays or visit **www.fabhalta.com**

***Co-Pay Plus:** Limitations apply. 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 (excluding administrative fees). Patient is responsible for any costs once 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 the Program and discontinue support at any time without notice.

†**Vaccination Support:** Limitations apply. Please contact Novartis Patient Support at 833-99FABHA (833-993-2242) for more information.

The information herein is provided for educational purposes only. Novartis cannot guarantee health plan or reimbursement. Coverage and reimbursement may vary significantly by health plan, patient, and setting of care. It is the sole responsibility of the health care provider to select the proper codes and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient.

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

NOVARTIS

FABHALTA® (iptacopan) 200 mg capsules

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

3/25

FA-11345384

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FABHALTA® (iptacopan) START FORM

* = REQUIRED

1. Patient Information

* First Name | * Last Name | * Phone Number — *We'll keep you informed through non-marketing calls and texts.** ☐ Mobile ☐ Home

* Date of Birth (MM/DD/YYYY) | * Sex for Clinical Use: ☐ Male ☐ Female | OK to Leave Voicemail for FABHALTA: ☐ Yes ☐ No

* Address (No PO Box) | Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

* City | * State | * ZIP | Email

I give permission to disclose my personal health information to the following Caregiver (optional):

Caregiver Name | Relationship to Patient | Caregiver Phone Number — *We'll keep you informed through non-marketing calls and texts.** ☐ Mobile ☐ Home

2. Patient Authorization and Additional Enrollment Consents

I have read and agree to the Patient Authorization on page 4.

X _____ * **Patient/Authorized Representative Signature** | * **Date (MM/DD/YYYY)** ☐ Check here if signed by an Authorized Representative.

CO-PAY PLUS† FOR FABHALTA

Pay as little as $0

☐ I have read and agree to the Co-Pay Plus Terms and Conditions on page 4.

GET ACCESS TO ONGOING SUPPORT

☐ I'd like to sign up for access to ongoing support. I'll get FABHALTA tips, resources, and reminders from Novartis Patient Support at the mobile phone number(s) I gave above.

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3. Insurance Information

Please include a copy (front and back) of the patient's insurance card(s) and/or complete the section below.

Check all that apply: ☐ Patient Is Uninsured ☐ Image(s) of Insurance Card(s) Included

* Pharmacy Insurance

If separate from medical insurance.

☐ Private ☐ Medicare Advantage ☐ Medicare Part D ☐ Medicaid ☐ Other: _____

Insurance/Payer | Plan Name | Policy Phone Number

Member ID Number | Rx Group Number

PCN Number | BIN Number

Primary Medical Insurance

☐ Private ☐ Medicare Advantage ☐ Medicare A/B ☐ Medicaid ☐ Other: _____

Insurance/Payer | Plan Name | Policy Phone Number

Member ID Number | Group Number

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FABHALTA (iptacopan) START FORM

* = REQUIRED

* **Patient Name**

* **Date of Birth (MM/DD/YYYY)**

4. Prescriber Information

* First Name

* Last Name

* Practice Name

* Address

* Practice Phone Number

* Practice Fax

* City

* State

* ZIP

Practice Contact Name

* Prescriber NPI Number

Practice Contact Phone Number

5. Additional Information

* **Primary Diagnosis Code:**

☐ D59.5 Paroxysmal nocturnal hemoglobinuria (PNH)

☐ N02.B____ Recurrent and persistent immunoglobulin A nephropathy (IgAN)

☐ Other:_____

Complement 3 glomerulopathy (C3G)

☐ N0_____.A C3 glomerulonephritis (C3GN)

☐ N0_____.6 Dense deposit disease (DDD)

Has your patient previously taken any treatments for their current condition in the past? ☐ Yes ☐ No

If yes, please indicate: _____

6. Vaccination Information

FABHALTA is available through a Risk Evaluation and Mitigation Strategy (REMS) program. Additional information is available by telephone at 866-201-3101 or online at www.FABHALTA-REMS.com.

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* **Please select one of the options below and sign the prescriber attestation:**

☐ **SHIP AS SOON AS POSSIBLE—NO PRESCRIBER HOLD**
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history and certify that vaccinations will be completed OR antibiotic prophylaxis will be prescribed and vaccines will be administered as soon as possible. FABHALTA is authorized to be dispensed as soon as possible.

OR

☐ **HOLD SHIPMENT BUT START INSURANCE PROCESS—PRESCRIBER WILL BE CONTACTED FOR RELEASE**
I have reviewed the FABHALTA vaccination requirements and my patient's vaccination history, and I request that the FABHALTA shipment be held with additional follow-up provided to my office as necessary.

Please mark the checkbox relevant to your patient's vaccination support needs. A dedicated Novartis Patient Support team member will follow up with your patient and provide more information.

☐ My patient requires vaccination support‡ to help comply with REMS requirements plus other Novartis Patient Support services

☐ My patient requires vaccination support‡ to help comply with REMS requirements

Please provide relevant vaccination and antibiotic prophylaxis information for your patient below to support REMS requirements for FABHALTA:

▶ Antibiotic prophylaxis will be administered? ☐ Yes ☐ No If yes, start date: _____ (MM/DD/YYYY)

▶ Vaccines administered? Document the appropriate vaccine type, brand administered, and the administration date (using the MM/DD/YYYY format) of the most recent dose.

MenACWY

1st Dose Date: _____/_____/_____

☐ Menveo ☐ Menactra

☐ MenQuadfi ☐ Penbraya

2nd Dose Date: _____/_____/_____

☐ Menveo ☐ Menactra

☐ MenQuadfi ☐ Penbraya

MenB

1st Dose Date: _____/_____/_____

☐ Bexsero ☐ Trumenba ☐ Penbraya

2nd Dose Date: _____/_____/_____

☐ Bexsero ☐ Trumenba ☐ Penbraya

3rd Dose Date: _____/_____/_____

☐ Bexsero ☐ Trumenba

Pneumococcal

1st Dose Date: _____/_____/_____

☐ PCV13 ☐ PCV15 ☐ PCV20

☐ PCV21 ☐ PPSV23

2nd Dose Date: _____/_____/_____

☐ PCV15 ☐ PCV20 ☐ PPSV23

If applicable

Do Not Fax Patient Medical Records. An incomplete Start Form may delay the start of treatment.

Complete entire form and fax to Novartis Patient Support at 877-44FABHA (877-443-2242). Sign up online at www.covermymeds.health. Questions? Contact 833-99FABHA (833-993-2242).

Novartis Patient Support

FABHALTA (iptacopan) START FORM

* = REQUIRED

* **Patient Name** _____

* **Date of Birth (MM/DD/YYYY)** _____

7. Prescription Information

Preferred Specialty Pharmacy: ☐ Biologics ☐ CareMed ☐ Onco360 ☐ Other: _____

Please note: A patient's health plan may dictate specific specialty pharmacy.

Pharmacy Prescription[§]:

Product Information	Dosage	Quantity	Refills Rx
☐ FABHALTA 200 mg capsule	☐ 200 mg orally twice daily	☐ 60 capsules ☐ 180 capsules	☐ 11 refills, or ___ refills

Prescriber Attestation

I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the provider who has prescribed FABHALTA to the patient named on this form. I certify that any medication received from Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis"), or the Novartis Patient Assistance Foundation, Inc., and its service providers ("NPAF"), will be used only for the patient named on this form and will not be offered for sale, trade, or barter, returned for credit, or submitted for reimbursement in any form. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Novartis and NPAF may revise, change, or terminate their respective programs at any time.

I have discussed the Novartis Patient Support 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 Novartis Patient Support. To complete this enrollment, Novartis may contact the patient by phone, text, and email.

X _____

* **Prescriber Signature (Dispense as Written)** _____ **(Substitution Permissible)** _____ * **Prescriber Name (Print Name)** _____ * **Date (MM/DD/YYYY)** _____

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

Do Not Fax Patient Medical Records. An incomplete Start Form may delay the start of treatment.

Novartis Patient Support

Patient Authorization. I authorize my healthcare providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment, and prescription details ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") and the Novartis Patient Assistance Foundation, Inc., and its service providers ("NPAF") so they can provide the following support services (the "Services"):

- Help coordinate insurance coverage for, access to, and receipt of my medication.
- Communicate with me about possible financial assistance, including Novartis copay or NPAF programs, and, if I am enrolled, administer my participation in those programs.
- Communicate with me about my medication and treatment, including reminders, health and lifestyle tips, and product and other related information. Communications may be customized based on Personal Information obtained from my Providers.
- Conduct quality assurance and other internal business activities and ask for feedback related to the Services or my treatment.

In delivering the Services, Novartis and NPAF may share my Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with information collected from other sources and use that information to administer the Services. My pharmacies or other healthcare providers may receive payment from Novartis or NPAF for providing certain Services, such as medication or refill reminders, based on my enrollment or participation. Once I authorize disclosure of my Personal Information, it may no longer be protected by federal health privacy law and applicable state laws.

I understand I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling 833-99FABHA (833-993-2242) or by writing to:

Novartis Patient Support
Novartis Pharmaceuticals Corporation
One Health Plaza
East Hanover, NJ 07936-1080

This Authorization will expire 5 years after I sign it, or earlier if required by state law, unless I cancel it sooner. If I cancel it, I may no longer qualify for Services from Novartis or NPAF, but it will not impact my Provider's treatment or my insurance benefits. I also understand that if a Provider is disclosing my Personal Information to Novartis or NPAF on an authorized, ongoing basis, my cancellation will be effective with respect to that Provider as soon as they receive notice of my cancellation. Cancellation will not affect prior uses or disclosures.

*Novartis Patient Support may call and text you at the numbers provided for non-marketing purposes (e.g., to help you access and start on FABHALTA). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 833-99FABHA (833-993-2242).

†**Co-Pay Plus:** Limitations apply. 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 (excluding administrative fees). Patient is responsible for any costs once 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 the Program and discontinue support at any time without notice.

‡**Vaccination Support:** Limitations apply. Please contact Novartis Patient Support at 833-99FABHA (833-993-2242) for more information.

§**Bridge Program:** Limitations apply. Patients with commercial insurance, a valid prescription for FABHALTA, and a denial of insurance coverage based on a prior authorization requirement may receive a monthly maintenance dose for up to 12 months or until insurance coverage approval, whichever occurs first. Not available to patients whose medications are reimbursed in whole or in part by Medicare, Medicaid, TRICARE, VA, DoD or any other federal or state program, or where prohibited by law. A prior authorization and/or appeal of coverage denial must be submitted within 90 days to remain in the program. No purchase necessary. Program is not health insurance, nor is participation a guarantee of insurance coverage. Additional restrictions may apply. Novartis reserves the right to rescind, revoke or amend this Program without notice.

Please see full Prescribing Information, including Boxed WARNING and Medication Guide.

Please see full Novartis Pharmaceuticals Corporation Privacy Policy and the Mobile Terms of Use.

NOVARTIS

FABHALTA® (iptacopan) 200 mg capsules