SANDOZ one source®

Statement of Medical Necessity (SMN)

PLEASE DO NOT SEND ANY ADDITIONAL DOCUMENTATION.

Phone: 1-844-SANDOZ1 (1-844-726-3691) **Fax:** 1-844-726-3695

Hours of Operation: Monday – Friday, 8:00 AM to 8:00 PM ET

Required Field (*)

1. Product Selection

Indicate the patient's therapy*: ☐ ZARXIO® (filgrastim-sndz) ☐ ZIEXTENZO® (pegfilgrastim-bmez)

2. Select Services

By completing this form, I am requesting services on behalf of the patient, which may include a benefits investigation, help navigating the prior authorization (PA) process, appeals support, and patient financial assistance, if applicable. Please select the type of benefits investigation you would like completed. If neither is checked, both Pharmacy and Medical benefits investigation will be completed to determine optimal patient benefits:

☐ Medical and Pharmacy Benefits Investigations **(Recommended)**

☐ Medical Benefits Investigation Only

☐ Pharmacy Benefits Investigation Only

☐ Refer to Patient Assistance Program (patient is uninsured or underinsured). Please attach a prescription

☐ Co-pay assistance only

☐ In-home nurse injection training Requested training date: _____

3. Patient Information

Patient's First Name*: _____ MI: _____ Last Name*: _____ Gender: ☐ M ☐ F

Street Address*: _____ City*: _____ State*: _____ ZIP Code*: _____

Date of Birth*: _____ Email: _____ Home Phone #: _____ Cell Phone #: _____

Best time to call: ☐ Morning ☐ Afternoon ☐ Evening

4. Patient Insurance

☐ No Insurance (Skip to Section 5)

Medical Insurance: _____ Pharmacy Insurance: _____

Policy #: _____ Policy #: _____

Policy Holder Name: _____ Policy Holder Name: _____

Insurance Phone #: _____ Insurance Phone #: _____

Group #: _____ Group #: _____

5. Treatment and Prescription Information

Drug: _____

Primary ICD/Dx*: _____ Secondary ICD/Dx: _____

Dosage: _____ Frequency: _____

CPT Code(s): _____

6. Prescriber Information

Prescriber First Name*: _____ Prescriber Last Name*: _____

Prescriber Type/Specialty: _____ State where Licensed: _____ State License #: _____

NPI #*: _____ Tax ID #: _____

Practice/Facility Name*: _____ Facility Type: ☐ Physician Office ☐ Hospital Outpatient ☐ Hospital Inpatient

Facility Address*: _____ City*: _____ State*: _____ ZIP Code*: _____

Office/Primary Contact Name: _____ Title/Role: _____

Office Contact Primary Phone #*: _____ Primary Fax #*: _____

Email Address (Prescriber or Office Contact): _____

7. Patient Authorization

X _____ _____

Patient/Legal Guardian Signature* **Date of Signature***

☐ I have read and agree to the attached Patient Authorization (page 2).

☐ I have read and agree to receive text messages and calls as explained in the Telephone Consumer Protection Act (TCPA) consent on page 2 (optional).

☐ I have read and agree to the Terms and Conditions for participation in the Sandoz One Source Co-Pay Assistance Program on page 2.

☐ I have read and agree to the Novartis Patient Assistance Foundation (NPAF) and Fair Credit Reporting Act Authorization on page 2 (optional).

8. Prescriber Authorization

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Sandoz, its employees, and Sandoz contractors to assist in obtaining coverage for ZARXIO or ZIEXTENZO and to assist in initiating or continuing ZARXIO or ZIEXTENZO therapy. I further certify that (a) any service provided through Sandoz One Source on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use ZARXIO or ZIEXTENZO or any other Sandoz product or service for anyone, and (b) my decision to prescribe ZARXIO or ZIEXTENZO was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any medication or service provided by or through Sandoz One Source for any government program or third-party insurer. For the purposes of transmitting prescriptions, I authorize NPAF, Sandoz, and its affiliates, business partners, and agents to forward as my agent for these limited purposes these prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies.

X _____ _____

Prescriber Signature* **Date of Signature***

☐ I have read and agree to the Prescriber Authorization for the NPAF on page 2 (if applicable).

7. Patient Authorization (continued)

Please read the following carefully, then sign and date where indicated on the previous page.

I give permission for my health care providers (HCPs), pharmacies, health insurer(s), third party contractors, and service providers to disclose my personal information, including information about my insurance, prescriptions, medical condition, and health ("Personal Information") to Sandoz, its affiliates, business partners, and agents (together "Sandoz") and to the Novartis Patient Assistance Foundation, Inc. ("NPAF") so that the Sandoz and the NPAF can (i) help verify or coordinate insurance coverage or otherwise obtain payment for my treatment with ZARXIO or ZIEXTENZO, (ii) coordinate my receipt of and payment for ZARXIO or ZIEXTENZO, (iii) facilitate my access to ZARXIO or ZIEXTENZO, (iv) provide me with information about ZARXIO or ZIEXTENZO, disease awareness, management programs, and educational materials, (v) manage the Sandoz One Source program, (vi) provide me with adherence reminders and support, (vii) conduct quality assurance, surveys, and other internal business activities in connection with the Sandoz One Source program, and (viii) if I choose to apply to programs offered by the NPAF, to administer those programs, to send me information about programs that might help me pay for my medicines, and to coordinate and share my Personal Information with my health care providers, other programs that might help me pay for medicines, government agencies, and insurance companies for purposes of providing or facilitating this assistance.

I give permission to Sandoz and the NPAF to disclose my Personal Information to my health care providers, pharmacies, health insurer(s), caregivers, and other third-party contractors or service providers for the purposes described above.

I understand that my pharmacy, health insurer(s), and health care providers may receive remuneration (payment) from the Sandoz in exchange for disclosing my personal information to Sandoz and/or for providing me with therapy support services.

I understand that once my Personal Information is disclosed it may no longer be protected by federal and state privacy law. I understand that I may refuse to sign this authorization. I also may revoke (withdraw) this authorization with respect to the Sandoz One Source Program at any time in the future by calling [1-844-726-3691]. I also may revoke (withdraw) this authorization with respect to NPAF at any time in the future by calling [1-800-277-2254].

My refusal or future revocation will not affect the commencement or continuation of my treatment by my doctors; however, if I revoke this authorization, I may no longer be able to participate in the Sandoz One Source Program and/or programs administered by NPAF. If I revoke this authorization, Sandoz and/or NPAF will stop using or sharing my information (except as necessary to end my participation in the program and/or NPAF) but my revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization. I understand that this authorization will remain valid for five (5) years after the date of my signature, unless I revoke it earlier. I also understand that the Sandoz One Source Program and/or programs administered by NPAF may change or end at any time without prior notification. I understand that I may receive a copy of this authorization.

I agree to be contacted by Sandoz and NPAF by mail, e-mail, telephone calls, and text messages at the number(s) and address(es) provided on the Statement of Medical Necessity form for all purposes described in this Patient Authorization. I also agree to be contacted by Sandoz, NPAF, and others on its behalf by telephone calls and text messages made by or using an automatic telephone dialing system or pre-recorded voice, at the number(s) provided on this form, for all non-marketing purposes, including but not limited to sending me materials and asking for my participation in surveys. I confirm that I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided, and I agree to notify Sandoz and/or NPAF promptly if any of my numbers or addresses change in the future. I understand that my wireless service provider's message and data rates may apply.

I understand that Sandoz and NPAF do not permit my Personal Information to be used by its business partners for their own separate marketing purposes. I understand and agree that Personal Information transmitted by e-mail and cell phone cannot be secured against unauthorized access.

Telephone Consumer Protection Act (TCPA) Consent: I consent to receive marketing and non-marketing calls and texts from and on behalf of Sandoz and NPAF, made with an autodialer or prerecorded voice, at the phone number(s) provided. I understand that my consent is not required or a condition of purchase. Number of messages will vary based on your program selections; average of 1-2 messages per week. Message and data rates may apply. Privacy Policy at [www.usprivacy.novartis.com]. Text STOP to opt out and HELP for help.

Co-Pay Assistance Program Terms and Conditions: I understand that this offer is only valid for those with commercial insurance and who have a valid prescription. I understand that this offer is not valid under Medicare, Medicaid, or any other federal or state program (eg, VA, DoD, Tricare), for cash-paying patients, where product is not covered by patient's commercial insurance, or where the plan reimburses the patient for the entire cost of his/her prescription drug. I also understand that this offer is not valid where prohibited by law and is only valid in the United States and Puerto Rico. Additional terms and conditions may apply. Sandoz reserves the right to rescind, revoke, or amend the program without notice. Finally, Sandoz may use the information you provide to contact you to remind you that your co-pay assistance is about to expire and to confirm your eligibility to continue participating in co-pay assistance.

Novartis Patient Assistance Foundation, Inc. (NPAF) and Fair Credit Reporting Act (FCRA) Authorization: I understand that I am providing "written instructions" authorizing NPAF and its vendor, under the FCRA, to obtain information from my credit profile or other information from Experian Health, solely for the purpose of determining financial qualifications for programs administered by NPAF. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide are complete and true and, unless I have indicated otherwise, I have no drug insurance coverage, which includes Medicaid, Medicare, or any public or private assistance programs or any other form of insurance. If my income or health coverage changes, I will call NPAF at [1-800-277-2254]. If eligible, I would like to be considered for programs administered by NPAF.

Prescriber Authorization for the Novartis Patient Assistance Foundation, Inc. (NPAF): I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Further, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that NPAF may revise, change, or terminate programs at any time.

Steps for Completing the SMN for Sandoz One Source

Step 1:	Please select the services requested.
Step 2:	Please select the patient's therapy.
Step 3:	Complete patient's personal information.
Step 4:	Provide the patient's insurance information. If available, please provide a front and back copy of the patient's pharmacy and medical insurance cards. If the patient does not have insurance, please select "No Insurance."
Step 5:	Please complete the approval diagnosis and prescription information.
Step 6:	Please provide information about your practice.
Step 7:	Please have the patient sign and date the patient authorization. Please ensure the appropriate boxes are checked for co-pay support and the Novartis Patient Assistance Program ("PAP") if applicable.
Step 8:	Please sign and date the prescriber authorization. Please ensure the Novartis Patient Assistance Program ("PAP") box is checked if referring the patient to the PAP.
	Once you have completed the form, please fax the completed information to Sandoz One Source at 1-844-726-3695.

SANDOZ A Novartis Division

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