

**EPASS™**  
**(EXJADE® PATIENT ASSISTANCE AND SUPPORT SERVICES)**  
**PRESCRIPTION AND REIMBURSEMENT APPLICATION**  
**Phone: 1-888-90-EPASS (1-888-903-7277)**

• Please complete each section, sign, and fax both pages •

**PRESCRIBER INFORMATION 1**

Prescriber Name: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 State License #: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 National Prescriber Identification (NPI) #: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Office Contact Name: \_\_\_\_\_

**CLINICAL INFORMATION 2**

Prior or current Desferal®/deferroxamine patient?  YES  NO  
**Check all that apply:**  
 Transfusion Protocol  Intermittently Transfused  
 Prior transfusion history not currently transfused

# of Years on Transfusion: \_\_\_\_\_ Serum Ferritin Level: \_\_\_\_\_  
 Primary Diagnosis: \_\_\_\_\_  
 ICD-9 Code: \_\_\_\_\_

**PRESCRIPTION INFORMATION 3**

Drug: EXJADE® (deferiasirox) # of Days Supplied: \_\_\_\_\_  
 # of Refills: \_\_\_\_\_ Patient Weight (kg): \_\_\_\_\_  
 Total Daily Dose: \_\_\_\_\_ (must be divisible by 125 mg)  
 Frequency: \_\_\_\_\_  
 Other Prescribing Information: \_\_\_\_\_

**PRESCRIBER CONSENT 4**

I acknowledge that I have assisted the patient in enrolling in the EPASS System exclusively for the purpose of patient care. I certify that I am prescribing the drug listed above for the patient listed to the right, and I authorize Novartis and its agents who have been hired to administer the EPASS System (collectively "Novartis") to transmit this prescription form electronically, by facsimile, or by mail to a dispensing pharmacy. I appoint Novartis as my agent to convey on my behalf to the dispensing pharmacy the prescription described herein. In addition, if agreed upon with the patient, I understand that the dispensing pharmacy may send the medication to my office to deliver to the patient. I understand and agree that I will receive information regarding the medication compliance of my patients. I agree that I will not seek reimbursement for any medication provided hereunder from any government program or third party insurer.

\_\_\_\_\_

**Prescriber Signature (no stamps)**

**PATIENT INFORMATION 5**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Gender:  M  F Language Preference: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Alternate Contact: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Best Time to Call:  AM  PM

**PRESCRIPTION DRUG INSURANCE INFORMATION 6**

Do you have prescription coverage?  YES  NO  
 If no, you will be contacted to discuss alternate coverage.  
 If yes, either complete the following section **or submit an enlarged photocopy of the front and back of your Rx card.**

**Prescription Insurer Name:** \_\_\_\_\_  
 Rx Bin #: \_\_\_\_\_ Rx PCN # (if applicable): \_\_\_\_\_  
 Rx Group #: \_\_\_\_\_ ID #: \_\_\_\_\_  
 Name on Card: \_\_\_\_\_  
 Pharmacy Services Phone # (back of card): \_\_\_\_\_  
 Patient Specialty Pharmacy Preference:  No Preference  
 Accredo Health Group  BioScrip  US Bioservices

**Medical/Secondary Insurer:** \_\_\_\_\_  
 Policy Holder's Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ MD's Provider #: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

**PATIENT CONSENT/AUTHORIZATION 7**

I have read, understood, and signed the patient consents/authorizations on page 2 of this application form and understand that my physician will be notified of my enrollment and treatment status, as well as my compliance with medication.

\_\_\_\_\_

**Signature of Patient or Patient's Representative**

\_\_\_\_\_

**Name (print) Date**

**Consent/Authorization to Disclose Health Information**

**Print Patient Name**

I authorize my Doctor and his/her staff to disclose my health information and any other personal information (as noted on page one of this form) to Novartis Pharmaceuticals Corporation, its affiliates, and its agents who have been hired to administer the Novartis EPASS System and/or the Novartis Patient Assistance Program (collectively, “Novartis”) for these organizations to use and/or disclose among Novartis my health information to help coordinate my receipt and proper administration of my medication, which will be prescribed by my Doctor. I also authorize my employer and health insurer to disclose information about my health insurance coverage to Novartis in order to coordinate my receipt of the medication.

**Signature of Patient or Patient’s Representative**

**Date**

(If signed by Representative, explain authority to act for the Patient.)

I also authorize Novartis to disclose information it receives about me to the specialty pharmaceutical company (the “Pharmacy”) that will fill my prescription and help manage certain aspects of its administration, and which will report back to Novartis regarding my compliance with medication. In addition, the Pharmacy may invite me to participate in medication management programs and receive educational materials related to my therapy.

I understand that once my health information is disclosed, neither my Doctor, my employer, nor my health insurer can guarantee that it will not be redisclosed to a third party. However, I understand that Novartis will not release my information to any party other than the Pharmacy and my prescribing physician without first obtaining my (or my authorized representative’s) separate written authorization.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that my refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my Doctor.

I understand that this Consent/Authorization will remain in effect for five years from the date of my signature, unless I revoke it earlier by calling the EPASS System’s toll-free number (888-903-7277). I understand that if I revoke this Authorization I will no longer be able to participate in the EPASS System and receive my medication.

I also understand that the EPASS System can be changed or ended at any time, without prior notification.

I understand that I have the right to receive a copy of this Authorization.

**Signature of Patient or Patient Representative**

**Date**

(If signed by Representative, explain authority to act for the Patient.)