PLUVICTO Co-pay Claim Request Form

PLUVICTO®
lutetium Lu 177 vipivotide tetraxetan
INJECTION FOR INTRAVENOUS USE

For health care providers (HCPs) only

The fields below are required to be filled out **only** by HCPs. If the claim is approved, reimbursement will be provided via check or electronic funds transfer (EFT).

Administering provider

* = REQUIRED FIELDS

* Practice name: _____
* Provider first name: _____ * Provider last name: _____
* Provider NPI: _____ * Site NPI: _____
* Site address: _____
* Site city: _____ * Site state: ____ * Site ZIP Code: _____
* Email address: _____

Patient information

* Patient first name: _____ * Patient last name: _____
* ZIP Code: _____ * Date of birth: _____ ☐ Male ☐ Female ☐ Other
* Co-pay program group #: _____ * Co-pay program member ID #: _____

The co-pay program group and member ID numbers are listed on the co-pay enrollment confirmation fax that you received for this patient. If you are unable to locate this information, please contact us at 1-844-638-7222.

Co-pay claim payment information

* Check payable to: _____
* Provider payment remittance address (if different from site address): _____

_____

* City: _____ * State: _____ * ZIP Code: _____

Email address: _____

Fax number: _____ * NPI number: _____ * Tax ID number: _____

* Preferred method of payment (select one): ☐ Check ☐ EFT

If you select EFT, an email address must be provided above.

* **Please fax the following documents to 1-631-822-2893 to complete the process. Payments will not be processed without the following items.**

Provide the Explanation of Benefits (EOB), which must include:

• Patient name • A-code or drug name • Date of service

If the above is not included in the EOB, please also submit a copy of the CMS-1500 or CMS-1450/UB-04 form.

Certification Statement

I certify that the information provided in this claim is accurate, and that expenses requested for payment were eligible, actually incurred, and were not and will not be paid by insurance, a flexible spending account, health savings account, or any other payer. I certify that the patient is not covered under Medicare, Medicaid, TRICARE, Veterans Affairs (VA), Department of Defense (DoD), or any other government (state or federally funded) program and that my use of this form is not prohibited by federal or state law. I understand and agree that I am liable for any misrepresentations herein to the full extent of applicable law.

* **Acknowledged and agreed (signature required):** _____ * **Date:** _____

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Send all necessary information to:

Mail to:

Novartis Patient Support Co-pay Program
77 Corporate Dr
Bridgewater, NJ 08807

OR

Fax to:

1-631-822-2893

Have questions?
Contact the Novartis Patient Support Co-pay Program at 1-844-638-7222.

Novartis Patient Support Co-pay Program Terms & Conditions

Limitations apply. Valid only for those with private insurance. The Program provides that an eligible patient will be responsible for the first $0 and then may receive assistance for up to a maximum of $15,000 over the course of the treatment to cover eligible out-of-pocket costs for the product. 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 toward patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles. Program is not valid where prohibited by law. 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 and Puerto Rico. 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.

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