PLUVICTO Co-pay Claim Request Form

PLUVICTO®
lutetium Lu 177 vipivotide tetraxetan
INJECTION FOR INTRAVENOUS USE

For patients

Please fill out page 1 and read the Novartis Patient Support Co-pay Program terms and conditions on page 2.

Find out if you may be able to get co-pay support

1. Fill out all the information on this page
2. Read and sign the certification statement at the bottom of this page
3. Mail this form to: **Novartis Patient Support Co-pay Program, 77 Corporate Dr, Bridgewater, NJ 08807** or fax this form to **1-631-822-2893**
4. Send all required information noted below with this form

Patient information

* = REQUIRED FIELDS

* Patient first name: _____ * Patient last name: _____

* Date of birth: _____ ☐ Male ☐ Female ☐ Other

* Co-pay program group #: _____ * Co-pay program member ID #: _____

(If you do not have a co-pay program group or member ID number, please contact us at 1-844-638-7222.)

Co-pay claim payment information

Write your or your doctor's address, depending on who is receiving reimbursement. Please also include your doctor's information below:

* Street address: _____

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

* Provider name: _____ * Provider phone: _____

(If you are receiving reimbursement, it will be sent via check.)

* Required information

To submit a claim, you will also need to provide:

- Explanation of Benefits (EOB) from your insurance provider
- A copy of the front and back of your insurance card(s)
- Proof of payment (a receipt is required if you are requesting to be paid back)

If any of the above is missing, the claim will not be paid.

THEN

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

OR

Fax to **1-631-822-2893**

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 I am 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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OR

Fax to:

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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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