NOVARTIS | PATIENT ASSISTANCE FOUNDATION, INC.

PRESCRIBER APPLICATION

1 Prescriber Information

* = REQUIRED FIELDS

First Name* | Last Name*

Practice Name: Abington Neurological Associates

Address*: 1151 Old York Road, Suite 200

Practice Phone Number: 215-957-9250

City*: Abington | State*: PA | ZIP*: 19001

Office Contact Name | Office Contact Phone

Provider NPI Number*

Office Fax*: 215-957-9254

State License Number

Office Email: abingtonneuro@abingtonneurology.com

2 Patient Information

First Name* | Last Name*

Date of Birth (MM/DD/YYYY)* | Sex for Clinical Use*: ☐ Male ☐ Female

FDO Date (if applicable)

3 Prescription

Medication Brand Name	Strength	Directions	Quantity	Refills
	If an injectable: ☐ Pen ☐ Syringe ☐ Cartridge		☐ 90 days ☐ Other: _____	☐ 1 year ☐ Other: _____
	If an injectable: ☐ Pen ☐ Syringe ☐ Cartridge		☐ 90 days ☐ Other: _____	☐ 1 year ☐ Other: _____

4 Prior Authorization

If the patient is insured and the insurance requires a Prior Authorization (PA), you must submit a copy of the PA and/or Appeal outcome for the medication.

5 Provider Attestation

Prescriber must authorize these instructions by signing at the end of this section.

I certify that the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify that I am the provider who has prescribed the drug identified above 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. For the purposes of transmitting this prescription, I authorize NPAF and its affiliates, business partners, and agents to forward, as my agent for these limited purposes, this prescription electronically, by facsimile, or by mail to the appropriate dispensing pharmacies.

I have discussed NPAF 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 NPAF. To complete this enrollment, Novartis may contact the patient by phone, text, or email.

X _____ / / _____

Provider Signature* (Dispense as Written) | **Date (MM/DD/YYYY)**

ATTN: Please follow your state's prescribing guidelines for electronic prescriptions.

Complete the entire form and fax to NPAF at **1-855-817-2711** or mail to: **NPAF, PO Box 2529, Columbus, OH 43216**
An incomplete form will result in a processing delay or application denial.

Visit Website www.PAP.Novartis.com
Send Fax 1-855-817-2711
Questions? Call 1-800-277-2254
Mail to PO Box 2529 Columbus, OH 43216