NOVARTIS

www.PAP.Novartis.com
Phone: 1-800-277-2254 Fax: 1-(855)-817-2711
P.O. Box 2529 Columbus, OH 43216
Monday-Friday 8:00 a.m. to 8:00 p.m.

Novartis Patient Assistance Foundation, Inc. (NPAF)

RE: Request for Denial Appeal

Dear Patient

Thank you for contacting the Novartis Patient Assistance Foundation (NPAF) to request an appeal of your denial to the NPAF program.

Denials will only be reconsidered if one or more of the following apply:

- Change in income/household size/employment status
- Change in insurance coverage for Novartis medication
- Correction to information provided in original enrollment

Note: Changes in personal expenses, having private/commercial insurance or being approved for Medicare Extra Help will not be accepted for appeal.

Please review and complete the attached form and submit any supporting documentation.

Applications may take up to three weeks for processing. You will receive a letter with the final outcome.

If you need assistance or have any questions, please call NPAF at: 1-800-277-2254, Monday through Friday, 8:00 AM to 8:00 PM ET.

Sincerely,
Novartis Patient Assistance Foundation, Inc.

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Novartis Patient Assistance Foundation, Inc.
Denial Reconsideration Application

Patient Name:

Patient ID:

Requested Novartis Medication:

Note: If you were denied for multiple Novartis medications, please list them here:

_____

1. Please check the box(es) below that apply to your situation
2. Describe your situation below
3. Attach copies of your updated income and/or insurance documents

I certify that it is difficult for me to afford my Novartis medication and I am requesting NPAF to reconsider the denial of my application for the following reason(s) (*select all that apply*)**:**

- ☐ I have had a change in my income/household size/employment status (you must attach updated annual household income, updated tax return or documents totaling all annual household income)
- ☐ I have had a change in my insurance coverage
- ☐ I need to correct information in my enrollment application

Note: Changes in personal expenses, having private/commercial insurance or being approved for Medicare Extra Help will not be accepted for appeal.

Please describe the changes in income and/or change in insurance:

_____

_____

_____

_____

_____

_____

_____

I confirm that the information provided on the above form and in the attached documents is complete and accurate to the best of my knowledge.

_____

Patient Signature _____

Date _____

Novartis Patient Assistance Foundation, Inc., at its sole and absolute discretion, reserves the right to modify or discontinue the program at any time and to verify the accuracy of the information submitted.