ILARIS®
(canakinumab)
150 mg subcutaneous injection

Patient Reimbursement Request Form

To see if ILARIS Companion can reimburse you for medication or treatment, please:

1. Fill out the Patient Information section below.
2. Make copies of your medical or pharmacy information to submit with this form.
3. Sign the Certification Statement at the end of this form.
4. Mail or fax your request, receipts, and Certification Statement to:

   ILARIS Co-Pay Program, ILARIS® (canakinumab), Claims Processing Department, 77 Corporate Dr., Bridgewater, NJ 08807 **Telephone**: 1-866-972-8315 **Fax:** 1-866-972-8316

Patient Information

Last Name:		First Name:	
Date of Birth:		ZIP Code:	
Sex for Clinical Use:	☐ Male ☐ Female	Paid Amount ($):	
Co-Pay Group #:		Patient Co-Pay ID #:	

Helpful Tip **You can find your Co-Pay Group # and Co-Pay ID # in your ILARIS Co-Pay Program email communication**

Supporting Materials

If you are submitting for reimbursement for qualifying payments you made to a healthcare provider/site of care, please provide:

- Explanation of Benefits (EOB) from your insurance provider and/or[CMS-1500 or CMS-1450/UB-04]form from your healthcare provider
- Proof of payment
- A copy of the front and back of your insurance card(s)

If you are submitting for reimbursement for qualifying payments you made to a pharmacy, please provide original receipt or invoice, including:

- Patient name and address
- Pharmacy name, address, and phone number
- Healthcare provider name, address, and phone number
- Prescription number, fill date, drug name, strength, National Drug Code number, and quantity
- Overall prescription price and co-pay amount paid
- A copy of the front and back of your prescription card

Mail or fax this completed form and supporting materials to:

ILARIS Co-Pay Program Claims Processing Department
77 Corporate Dr. Bridgewater, NJ 08807
Fax: 1-866-972-8316

Questions? Your ILARIS Companion can help. Call 1-866-972-8315

Don't Forget! **If you don't include all the required information, your claim will be rejected**

ILARIS Co-Pay Program Terms & Conditions

*Terms and Conditions: Limitations apply. Valid only for those with private insurance. The Program includes the Co-pay Card, Payment Card (if applicable), and Rebate, with a combined annual limit of [$36,000]. 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 towards 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.

Patient Certification Statement

I certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by insurance, a flexible spending account (FSA), health savings account (HSA), or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, VA, 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 *(Patient signature required):* _____ Date:_____

Please allow 4-6 weeks for processing claims. Successful claims will be processed and paid in the subsequent billing cycle.

NOVARTIS

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Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

10/24 FA-11258078