ILARIS®
(canakinumab)
150 mg subcutaneous injection

Provider Claim Reimbursement Request Form

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

Please complete this form and submit with all required information and attachments to be considered for reimbursement. This offer is valid only for patients with private insurance who are otherwise eligible. Please see page 2 for full program Terms and Conditions.

1 To request payment for the benefit of, and on behalf of, your patient in an amount up to or equal to your eligible patient's out-of-pocket expenses for medication covered under the medical benefit as "buy-and-bill," pursuant to the program Terms and Conditions, **the following healthcare provider information is REQUIRED.**

Please fill out this form for co-pay reimbursement for ILARIS and make sure to acknowledge and agree with the provider signature at the bottom.

2 Please **fax** this completed form and the following documents to 1-866-972-8316 to complete the process. Payments will not be processed without the following items:

- The Explanation of Benefits (EOB), which must include
  - Patient name
  - Drug name
  - Date of service

3 Once a claim is approved, a check will be sent to the site address listed in the Healthcare Provider Information section below.

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

Healthcare Provider Information			
Provider's Last Name:		Provider's First Name:	
Provider's NPI:		Provider's State License #:	
Site Name:		Site NPI:	
Email *(required for electronic fund transfer)*:		Site Address:	
Site City:		Site State and ZIP Code:	
Co-Pay Group #:		Patient Co-Pay ID #:	

NPI=National Provider Identifier.

ILARIS Co-Pay Program Terms and 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.

Certification Statement

I certify that the information provided herein is accurate; that expenses requested for payment are eligible, actually incurred, and not paid by the patient's insurance, Flexible Spending Account, Health Savings Account or any other health plan; and that I would, in the ordinary course of my practice, have charged my patient for such out-of-pocket expenses. I also certify that every patient for whom I submit for co-pay reimbursement and receive co-pay reimbursement (i) is not insured under Medicare, Medicaid, TRICARE, or any other government (state or federally funded) program; and (ii) meets the other eligibility criteria specified in the Terms & Conditions. I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

Acknowledged and agreed (Authorized representative signature required):

_____ Date:_____

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