

EXJADE® is indicated for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis) in patients 2 years and older. Further studies are being performed to determine the long-term benefits and risks of EXJADE.

Clinical trials to demonstrate increased survival or to confirm clinical benefit have not been completed.

Individualize the decision to initiate EXJADE therapy based on consideration of the anticipated clinical benefit and risks of the therapy, taking into consideration factors such as the life expectancy and comorbidities of the patient.

The safety and efficacy of EXJADE when administered with other iron chelation therapy have not been established.

• Please complete each section, sign, and fax both pages •

PRESCRIBER INFORMATION 1

Prescriber Name: _____
 Specialty: _____
 State License #: _____ DEA #: _____
 National Prescriber Identification (NPI) #: _____
 Phone: _____ Fax: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Office Contact Name: _____

CLINICAL INFORMATION 2

EXJADE is contraindicated in patients with:

- Creatinine clearance <40 mL/min or serum creatinine >2 times the age-appropriate upper limit of normal;
- Poor performance status and high-risk myelodysplastic syndromes or advanced malignancies
- Platelet counts <50 x 10⁹/L;
- Known hypersensitivity to deferasirox or to any component of EXJADE.

Prior or current Desferal®/deferrioxamine patient? YES NO

Check one:

Transfusion Protocol:

- Chronically Transfused Intermittently Transfused
 Prior transfusion history but not currently transfused

of Years on Transfusion: _____

Serum Ferritin Level (within 1 to 4 weeks): _____

Primary Diagnosis: _____ ICD-9: _____

Reason for EXJADE® therapy: _____ ICD-9: _____

PRESCRIPTION INFORMATION 3

Drug: EXJADE® (deferasirox) # of Days Supplied: _____

of Refills: _____ Patient Weight (kg): _____

Total Daily Dose: _____ (must be divisible by 125 mg)

Tablet Strength (circle one): 125 mg 250 mg 500 mg

Frequency: _____

Other Prescribing Information: _____

PRESCRIBER CONSENT 4

I acknowledge that I have assisted the patient in enrolling in the EPASS System exclusively for the purpose of patient care. I certify that I am prescribing the drug listed above for the patient listed to the right, and I authorize Novartis and its agents who have been hired to administer the EPASS System (collectively "Novartis") to transmit this prescription form electronically, by facsimile, or by mail to a dispensing pharmacy.

I appoint Novartis as my agent to convey on my behalf to the dispensing pharmacy the prescription herein. In addition, if agreed upon with the patient, I understand that the dispensing pharmacy may send the medication to my office to deliver to the patient. I understand and agree that I will receive information regarding the medication compliance of my patients. I agree that I will not seek reimbursement for any medication provided hereunder from any government program or third party insurer.

Prescriber Signature (no stamps)

PATIENT INFORMATION 5

Patient Name: _____ DOB: _____

Gender: M F Language Preference: _____

Phone: _____ Alt. Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

Alternate Contact: _____

Relationship: _____ Phone: _____

Best Time to Call: AM PM

PATIENT COVERAGE INFORMATION 6

Do you have prescription coverage? YES NO

If no, you will be contacted to discuss alternate coverage.

If yes, either complete the following section **or submit an enlarged photocopy of the front and back of your Rx card.**

Prescription Insurer Name: _____

Rx Bin #: _____ Rx PCN # (if applicable): _____

Rx Group #: _____ ID #: _____

Name on Card: _____

Pharmacy Services Phone # (back of card): _____

Patient Specialty Pharmacy Preference: No Preference

Accredo Health Group BioScrip US Bioservices

Medical/Secondary Insurer: _____

Policy Holder's Name: _____

Phone: _____ MD's Provider #: _____

Group #: _____ Policy #: _____

PATIENT CONSENT/AUTHORIZATION 7

I have read, understood, and signed the patient consents/authorizations on page 2 of this application form and understand that my physician will be notified of my enrollment and treatment status, as well as my compliance with medication.

Signature of Patient or Patient's Representative

Name (print) Date

IMPORTANT SAFETY INFORMATION

WARNING: RENAL, HEPATIC FAILURE AND/OR GASTROINTESTINAL HEMORRHAGE

EXJADE may cause:

- Renal impairment, including failure
- Hepatic impairment, including failure
- Gastrointestinal hemorrhage

In some reported cases, these reactions were fatal. These reactions were more frequently observed in patients with advanced age, high risk myelodysplastic syndromes (MDS), underlying renal or hepatic impairment or low platelet counts (<50 x 10⁹/L).

EXJADE therapy requires close patient monitoring, including measurement of:

- Serum creatinine and/or creatinine clearance prior to initiation of therapy and monthly thereafter; in patients with underlying renal impairment or risk factors for renal impairment, monitor creatinine and/or creatinine clearance weekly for the first month, then monthly thereafter;
- Serum transaminases and bilirubin prior to initiation of therapy, every two weeks during the first month and monthly thereafter.

Please see additional Important Safety Information on p. 3.

Please see Full Prescribing Information on pages 4-18.



Consent/Authorization to Disclose Health Information

Print Patient Name

I authorize my Doctor and his/her staff to disclose my health information and any other personal information (as noted on page one of this form) to Novartis Pharmaceuticals Corporation, its affiliates, and its agents who have been hired to administer the Novartis EPASS System and/or the Novartis Patient Assistance Program (collectively, “Novartis”) for these organizations to use and/or disclose among Novartis my health information to help coordinate my receipt and proper administration of my medication, which will be prescribed by my Doctor. I also authorize my employer and health insurer to disclose information about my health insurance coverage to Novartis in order to coordinate my receipt of the medication.

Signature of Patient or Patient’s Representative

Date

(If signed by Representative, explain authority to act for the Patient.)

I also authorize Novartis to disclose information it receives about me to the specialty pharmaceutical company (the “Pharmacy”) that will fill my prescription and help manage certain aspects of its administration, and which will report back to Novartis regarding my compliance with medication. In addition, the Pharmacy may invite me to participate in medication management programs and receive educational materials related to my therapy.

I understand that once my health information is disclosed, neither my Doctor, my employer, nor my health insurer can guarantee that it will not be redisclosed to a third party. However, I understand that Novartis will not release my information to any party other than the Pharmacy and my prescribing physician without first obtaining my (or my authorized representative’s) separate written authorization.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that my refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my Doctor.

I understand that this Consent/Authorization will remain in effect for five years from the date of my signature, unless I revoke it earlier by calling the EPASS System’s toll-free number (888-903-7277). I understand that if I revoke this Authorization I will no longer be able to participate in the EPASS System and receive my medication.

I also understand that the EPASS System can be changed or ended at any time, without prior notification.

I understand that I have the right to receive a copy of this Authorization.

Signature of Patient or Patient Representative

Date

(If signed by Representative, explain authority to act for the Patient.)