

Novartis Patient Support

Phone: 1-844-638-7222 | Fax: 1-844-638-7329




Enrollment Form for Insurance Benefit Information for NETSPOT® (kit for the preparation of gallium Ga 68 dotatate)

NOTE: The enrollment cannot be processed without both prescriber and patient signatures.

Expected Date of NETSPOT Scan: _____


*Indicates Required Field

PATIENT INFORMATION		
*Patient Name:		*Date of Birth:
*Address:		*Sex: <input type="checkbox"/> M <input type="checkbox"/> F
*City:	*State:	*Zip Code:
*Phone No.: <input type="checkbox"/> Home: <input type="checkbox"/> Cell:		
*OK to leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cell <input type="checkbox"/> Home		
Alternate Contact Name:		Relationship:
Patient Email:		

PATIENT AUTHORIZATION  Required — CANNOT PROCESS FORM WITHOUT THIS COMPLETED	
 I CONFIRM THAT THE INFORMATION PROVIDED HEREIN IS TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE	
<input type="checkbox"/> I HAVE READ AND AGREE TO THE PATIENT AUTHORIZATION ON PAGE 4	
 STOP *PATIENT/LEGAL GUARDIAN SIGNATURE:	
*Print Patient/Legal Guardian Name:	*Relationship to Patient:
*Date:	

INSURANCE INFORMATION (Required for Benefit Verification and Co-pay Assistance)		
<input type="checkbox"/> Patient has no insurance		
Carrier 1		
*Carrier:	*Health Plan:	
*Carrier Phone No.:	*Policy ID No.:	
*Group No.:	*Policy Holder Name:	
*Policy Holder Sex: <input type="checkbox"/> M <input type="checkbox"/> F	*Policy Holder Date of Birth:	*Policy Holder Relationship:
Carrier 2		
Carrier:	Health Plan:	
Carrier Phone No.:	Policy ID No.:	
Group No.:	Policy Holder Name:	
Policy Holder Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Policy Holder Date of Birth:	Policy Holder Relationship:

Please see the full [Prescribing Information for NETSPOT](#).

PATIENT INFORMATION			
Name:		Date of Birth:	
PRESCRIBER INFORMATION			
*Ordering Physician Name:		*Specialty:	
*Physician Practice Name:		*Practice National Provider Identifier (NPI) No.:	
*Office Contact Name:	*Office Contact Phone No.:		Ext:
*Physician Address:			
*City:	*State:	*Zip Code:	
*Physician Phone No.:		*Physician Fax No.:	
Physician Email:			
*Physician NPI No.:	*State License No.:	*Tax ID No.:	
REFERRING PHYSICIAN INFORMATION			
*Ordering Physician Name:		*Specialty:	
*Physician Practice Name:		*Practice National Provider Identifier (NPI) No.:	
*Office Contact Name:	*Office Contact Phone No.:		Ext:
*Physician Address:			
*City:	*State:	*Zip Code:	
*Physician Phone No.:		*Physician Fax No.:	
Physician Email:			
*Physician NPI No.:	*State License No.:	*Tax ID No.:	
SITE-OF-TREATMENT INFORMATION			
*Administering Facility:		<input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Freestanding/Physician Office	
*Facility Address:			
*City:	*State:	*Zip Code:	
*Facility Phone No.:		*Facility Fax No.:	
*Facility NPI No.:		*Tax ID No.:	
*Facility Contact Person:		*Facility Contact Phone No.:	
Ext:			
CLINICAL INFORMATION			
*Primary and secondary International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes are required.			
Diagnosis (ICD-10-CM code):		Description:	
Diagnosis (ICD-10-CM code):		Description:	
**Include at least 1 Current Procedural Terminology (CPT) code below.			
CPT code:		Description:	
PHYSICIAN CERTIFICATION			
<p>I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I certify that I am the prescriber who has prescribed NETSPOT® (kit for the preparation of gallium Ga 68 dotatate) to the previously identified patient and that I provided the patient a description of the Novartis Patient Support Program. I authorize the Novartis Patient Support Program to act on my behalf for the purposes of determining the patient's eligibility for participation in the Novartis Patient Support Program. I agree to receive communications, including faxes, related to my patient's enrollment or participation in the Novartis Patient Support Program.</p> <p>I HAVE OBTAINED FROM MY PATIENT ALL REQUIRED AUTHORIZATIONS TO DISCLOSE TO NOVARTIS PATIENT SUPPORT AND ITS REPRESENTATIVES THE PATIENT'S PROTECTED HEALTH INFORMATION (PHI), INCLUDING THE INFORMATION PROVIDED ON THIS FORM. I ALSO AGREE THAT NOVARTIS MAY CONTACT THE PATIENT DIRECTLY IN CONNECTION WITH THE NOVARTIS PATIENT SUPPORT PROGRAM.</p>			
 STOP		*PHYSICIAN SIGNATURE:	
*Physician Printed Name:		*Date:	

Please see the full [Prescribing Information](#) for NETSPOT.

CLINICAL INFORMATION

ICD-10* Codes Most Frequently Associated With Somatostatin-Bearing Neuroendocrine Tumor Imaging (select 1 or more)

Code	Description	Code	Description
<input type="checkbox"/> C7A.00	Malignant carcinoid tumor of unspecified site	<input type="checkbox"/> D13.1	Benign neoplasm of stomach
<input type="checkbox"/> C7A.010	Malignant carcinoid tumor of the duodenum	<input type="checkbox"/> D13.2	Benign neoplasm of duodenum
<input type="checkbox"/> C7A.011	Malignant carcinoid tumor of the jejunum	<input type="checkbox"/> D13.30	Benign neoplasm of unspecified part of small intestine
<input type="checkbox"/> C7A.012	Malignant carcinoid tumor of the ileum	<input type="checkbox"/> D13.39	Benign neoplasm of other parts of small intestine
<input type="checkbox"/> C7A.019	Malignant carcinoid tumor of the small intestine, unspecified portion	<input type="checkbox"/> D14.30	Benign neoplasm of unspecified bronchus and lung
<input type="checkbox"/> C7A.020	Malignant carcinoid tumor of the appendix	<input type="checkbox"/> D15.0	Benign neoplasm of thymus
<input type="checkbox"/> C7A.021	Malignant carcinoid tumor of the cecum	<input type="checkbox"/> D30.00	Benign neoplasm of unspecified kidney
<input type="checkbox"/> C7A.022	Malignant carcinoid tumor of the ascending colon	<input type="checkbox"/> D3A.010	Benign carcinoid tumor of the duodenum
<input type="checkbox"/> C7A.023	Malignant carcinoid tumor of the transverse colon	<input type="checkbox"/> D3A.011	Benign carcinoid tumor of the jejunum
<input type="checkbox"/> C7A.024	Malignant carcinoid tumor of the descending colon	<input type="checkbox"/> D3A.012	Benign carcinoid tumor of the ileum
<input type="checkbox"/> C7A.025	Malignant carcinoid tumor of the sigmoid colon	<input type="checkbox"/> D3A.019	Benign carcinoid tumor of the small intestine, unspecified portion
<input type="checkbox"/> C7A.026	Malignant carcinoid tumor of the rectum	<input type="checkbox"/> D3A.020	Benign carcinoid tumor of the appendix
<input type="checkbox"/> C7A.029	Malignant carcinoid tumor of the large intestine, unspecified portion	<input type="checkbox"/> D3A.021	Benign carcinoid tumor of the cecum
<input type="checkbox"/> C7A.090	Malignant carcinoid tumor of the bronchus and lung	<input type="checkbox"/> D3A.022	Benign carcinoid tumor of the ascending colon
<input type="checkbox"/> C7A.091	Malignant carcinoid tumor of the thymus	<input type="checkbox"/> D3A.023	Benign carcinoid tumor of the transverse colon
<input type="checkbox"/> C7A.092	Malignant carcinoid tumor of the stomach	<input type="checkbox"/> D3A.024	Benign carcinoid tumor of the descending colon
<input type="checkbox"/> C7A.093	Malignant carcinoid tumor of the kidney	<input type="checkbox"/> D3A.025	Benign carcinoid tumor of the sigmoid colon
<input type="checkbox"/> C7A.094	Malignant carcinoid tumor of the foregut, unspecified	<input type="checkbox"/> D3A.026	Benign carcinoid tumor of the rectum
<input type="checkbox"/> C7A.095	Malignant carcinoid tumor of the midgut, unspecified	<input type="checkbox"/> D3A.029	Benign carcinoid tumor of the large intestine, unspecified portion
<input type="checkbox"/> C7A.096	Malignant carcinoid tumor of the hindgut, unspecified	<input type="checkbox"/> D3A.090	Benign carcinoid tumor of the bronchus and lung
<input type="checkbox"/> C7A.098	Malignant carcinoid tumors of other sites	<input type="checkbox"/> D3A.091	Benign carcinoid tumor of the thymus
<input type="checkbox"/> C7A.1	Malignant poorly differentiated neuroendocrine tumors	<input type="checkbox"/> D3A.092	Benign carcinoid tumor of the stomach
<input type="checkbox"/> C7B.00	Secondary carcinoid tumors, unspecified site	<input type="checkbox"/> D3A.093	Benign carcinoid tumor of the kidney
<input type="checkbox"/> C7B.01	Secondary carcinoid tumors of distant lymph nodes	<input type="checkbox"/> D3A.094	Benign carcinoid tumor of the foregut, unspecified
<input type="checkbox"/> C7B.02	Secondary carcinoid tumors of liver	<input type="checkbox"/> D3A.095	Benign carcinoid tumor of the midgut, unspecified
<input type="checkbox"/> C7B.03	Secondary carcinoid tumors of bone	<input type="checkbox"/> D3A.096	Benign carcinoid tumor of the hindgut, unspecified
<input type="checkbox"/> C7B.04	Secondary carcinoid tumors of peritoneum	<input type="checkbox"/> D49.511	Neoplasm of unspecified behavior of right kidney
<input type="checkbox"/> C25.0	Malignant neoplasm of head of pancreas	<input type="checkbox"/> D49.512	Neoplasm of unspecified behavior of left kidney
<input type="checkbox"/> C25.1	Malignant neoplasm of body of pancreas	<input type="checkbox"/> D49.519	Neoplasm of unspecified behavior of unspecified kidney
<input type="checkbox"/> C25.2	Malignant neoplasm of tail of pancreas	<input type="checkbox"/> Other:	
<input type="checkbox"/> C25.4	Malignant neoplasm of endocrine pancreas		
<input type="checkbox"/> C25.7	Malignant neoplasm of other parts of pancreas		
<input type="checkbox"/> C25.8	Malignant neoplasm of overlapping sites of pancreas		
<input type="checkbox"/> C25.9	Malignant neoplasm of pancreas, unspecified		
<input type="checkbox"/> D12.0	Benign neoplasm of cecum		
<input type="checkbox"/> D12.1	Benign neoplasm of appendix		
<input type="checkbox"/> D12.6	Benign neoplasm of colon, unspecified		
<input type="checkbox"/> D12.7	Benign neoplasm of rectosigmoid junction		
<input type="checkbox"/> D12.8	Benign neoplasm of rectum		
<input type="checkbox"/> D12.9	Benign neoplasm of anus and anal canal		

CPT* Codes Most Frequently Associated With PET Scan (select only 1)

- ☐ 78811 PET imaging; limited area (eg, chest, head/neck)
- ☐ 78812 PET imaging; skull base to mid-thigh
- ☐ 78813 PET imaging; whole body
- ☐ 78814 PET with concurrently acquired CT for attenuation correction & anatomical localization imaging; limited area (eg, chest, head/neck)
- ☐ 78815 PET with concurrently acquired CT for attenuation correction & anatomical localization imaging; skull base to mid-thigh
- ☐ 78816 PET with concurrently acquired CT for attenuation correction & anatomical localization imaging; whole body
- ☐ Other: _____

CT, computed tomography;
PET, positron emission tomography

***Disclaimer notice for list of possible codes:** This information is taken from publicly available sources. It is not intended to guarantee, increase, or maximize reimbursement by any payer. It is the provider's responsibility to report the codes that accurately describe the products and services furnished to individual patients. Reimbursement is dynamic. We recommend that providers consult their payer organizations regarding local policies and rates. Laws and regulations regarding reimbursement change frequently and providers are solely responsible for all decisions related to coding and billing including determining, if and under what circumstances, it is appropriate to seek reimbursement for products and services and obtaining preauthorization, if necessary. Novartis makes no representation or warranty regarding this information or its completeness or accuracy and will bear no responsibility for the results or consequences of the use of this information. You should reference the current CPT®, ICD-10-CM, and Healthcare Common Procedure Coding System (HCPCS) manuals and follow the "Documentation Guidelines for Evaluation and Management Services" for the most detailed and up-to-date information. Current Procedural Terminology (CPT®) is a copyright and registered trademark of the 2012 American Medical Association (AMA). All rights reserved.

Please see the full [Prescribing Information](#) for NETSPOT.

Novartis Pharmaceuticals Corporation
One Health Plaza
East Hanover, New Jersey 07936-1080

PATIENT AUTHORIZATION

Please read the following carefully, then sign and date where indicated on page 1.

I authorize my health care providers, pharmacies, health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment, and prescription details ("Personal Information") to Novartis Patient Support and the Novartis Patient Assistance Foundation, Inc ("NPAF") and its service providers so they can provide the following support services ("Services"):

- Help coordinate insurance coverage for, access to, and receipt of my medication
- Communicate with me about possible financial assistance, including Novartis Patient Support co-pay or NPAF programs, and, if I am enrolled, administer my participation in these programs
- Communicate with me about my medication and treatment, including reminders, health and lifestyle tips, and product and other related information. Communications may be customized based on Personal Information obtained from my Providers
- Conduct quality assurance and other internal business activities, and ask for feedback related to the Services or my treatment

In delivering the Services, Novartis Patient Support and NPAF may share Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with my information collected from other sources and use that information to administer the Services. My pharmacies or other health care providers may receive payment from Novartis Patient Support for providing certain aspects of the Services, such as medication or refill reminders, based on my enrollment or participation. Once I authorize disclosure of my Personal Information, it may no longer be protected by federal health privacy law and applicable state laws.

I understand that I do not have to sign this Patient Authorization to get my medication or insurance coverage, that I have a right to a copy, and that I can cancel this Authorization at any time by calling 1-844-638-7222 or by writing to Novartis Patient Support, 4199 Kinross Lakes Parkway, Suite 220, Richfield, OH 44286.

This authorization will expire 5 years after I sign it, or earlier if required by state law, unless I cancel it sooner. If I cancel it, I may no longer qualify for Services from Novartis Patient Support or NPAF, but it will not impact my Providers' treatment or my insurance benefits. I also understand that if a Provider is disclosing my Personal Information to Novartis Patient Support or NPAF on an authorized, ongoing basis, my cancellation with Novartis Patient Support or NPAF will be effective with respect to that Provider as soon as they receive notice of my cancellation. Cancellation will not affect prior uses or disclosures.

I agree for myself and certify (if applicable) that my caregiver agrees to receive nonmarketing calls and texts from Novartis Patient Support or NPAF, including through an autodialer or prerecorded voice, at the number(s) provided.

For more information on Novartis Patient Support programs related to NETSPOT, please visit www.novartis-patientsupport.com/RLT.

Rev. 2/23

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