Novo Nordisk
Product Assistance/Trial Program Application

NovoSecure™

novo nordisk®

Part 1 of 3: Provider Information

FOR HEALTHCARE PROVIDER

A

Patient's Name:

Date of Birth: ___/___/_____ (MM/DD/YYYY)

- ❑ Hemophilia A
- ❑ Hemophilia A or B with inhibitors
- ❑ Congenital factor VII deficiency
- ❑ Glanzmann's thrombasthenia with refractoriness
- ❑ Acquired hemophilia
- ❑ Congenital factor XIII A-subunit deficiency
- ❑ I certify that, to my knowledge, this patient is not enrolled in any Medicare, Medicaid, Department of Veterans Affairs, or other state or federally funded health plan.

B

Licensed Healthcare Provider Information

Name:	State License Number: Expiration Date: NPI Number:
Street Address (no PO Box number):	
City, State, and Zip Code:	
Office Phone: ___-___-____	Office Fax: ___-___-____
Office E-mail:	Office Contact Name:

C

Order Information (include prescription for 23G [adult] or 25G [pediatric] infusion supplies if applicable)

Product Name	Dose	Infusion Instructions	Quantity To Dispense

For questions regarding NovoSecure™, please call **1-844-NOVOSEC** (1-844-668-6732).

D

Healthcare Provider Declaration. My signature certifies that I am a licensed healthcare provider eligible under state law to prescribe the requested medication(s) listed on the attached order and that I am not prohibited from participating in federally funded healthcare programs. I further certify that all information provided in the Licensed Healthcare Provider Information section is correct. I understand that I am not eligible to seek reimbursement for any medication dispensed by the Novo Nordisk PAP from any government program or third-party insurer and will not apply any Novo Nordisk PAP medication toward the applicant's True-Out-Of-Pocket (TrOOP) costs. I also understand that eligibility under the PAP is subject to Novo Nordisk's discretion and that Novo Nordisk reserves the right to modify or terminate the PAP at any time. Finally, I certify that I receive no direct or indirect payments related to the PAP.

Healthcare Provider's Signature (no photocopies or power-of-attorney signature):	Date:
PROVIDER'S SIGNATURE	

Fax all forms and other required information to: 1-866-441-4190

 Printed in the U.S.A. 1214-00024620-1 April 2015

Novo Nordisk
Product Assistance/Trial Program Application

NovoSecure™

novo nordisk®

PO Box 370
Somerville, NJ 08876
Phone: 1-844-668-6732
Fax: 1-866-441-4190

☐ New Application
☐ Annual Renewal

Part 2 of 3: Patient Information

Be sure to read all instructions before completing forms. Please type or print legibly.

FOR PATIENT		
A	Patient's Name:	Date of Birth: ___/___/_____ (MM/DD/YYYY)
	Sex: ☐ Male ☐ Female	Social Security Number: ___-___-_____
	Patient's Shipping Address:	
	Patient's City, State, and Zip Code:	
	As part of this PAP, Novo Nordisk will provide me with refill reminders and notifications regarding program enrollment via phone calls. By checking the check box below, I hereby consent to receive: ☐ Autodialed and prerecorded calls to the phone number(s) provided below. I understand and agree that by checking this box and entering my phone number(s), I am granting my express written consent to receive autodialed and prerecorded phone calls from Novo Nordisk and its PAP service providers on my mobile phone and/or landline. I also understand that my consent is optional and can be freely withdrawn.	
	Phone: ___-___-_____	Mobile Phone: ___-___-_____
	E-mail:	
	Patient-Authorized Representative Information Name:	Relationship to Patient:
	Phone Number: ___-___-_____	

B	Does the patient have private insurance coverage of any kind? If yes, please fill out additional information in section C.	☐ Yes ☐ No

C	Plan Name:
	Plan Phone: ___-___-_____
	Policy Holder Name:
	Policy Number:
	Group Number:
	Processor Control Number (PCN):
	☐ I hereby certify that I am not enrolled in any Medicaid, Medicare, Department of Veterans Affairs, or other state or federal government health plan.

Healthcare provider's signature is required on Part 1.
Patient's or patient representative's signature is required on Part 3.
Fax all forms and other required information to: 1-866-441-4190

Novo Nordisk
Product Assistance/Trial Program Application

NovoSecure™

novo nordisk®

Part 3 of 3: Patient Certification and Authorization

FOR PATIENT

A

Patient Declaration. I certify:

- All information provided in this application is true and correct and that I will verify any of the information I provide to the Patient Assistance Program (PAP) upon request by the PAP
- To verify my PAP application status and receipt of the indicated medication(s) upon request by the PAP
- If approved to participate in the PAP, I will not seek reimbursement for the medication(s) requested from any government program or third-party insurer

I understand and agree:

- That my eligibility to participate in the PAP is subject to Novo Nordisk's decision and that Novo Nordisk may modify or terminate the PAP at any time
- That I may be required to provide proof of ineligibility for certain health insurance coverage in order to meet the eligibility requirements for the PAP
- That I am required to report any changes to my health insurance and prescription drug coverage to the PAP

Patient's or Patient Representative's Signature (no photocopies or power of attorney signature): PATIENT'S SIGNATURE	**Date:**

 Printed in the U.S.A. 1214-00024620-1 April 2015

Novo Nordisk Patient Authorization to Use and Disclose Health Information

NovoSecure™

novo nordisk®

Patient Authorization to Share Health Information. I give permission to my healthcare providers, my health plan, and insurers to give health and other information about my use of or need for medications provided under the PAP to third-party Novo Nordisk vendors in charge of administering the PAP. My health and other information is referred to below as "Information."

I give permission to Novo Nordisk and its third-party vendors to further use and disclose my Information in connection with the PAP. I understand:

- That people with the PAP, Novo Nordisk, or others working on behalf of the PAP or Novo Nordisk may see and use my Information for administering the PAP
- That my Information will include my name, address, Social Security number, prescription coverage, prescription for medication(s), and insurance records
- That my Information will be used to see if I meet the requirements to participate in the PAP, to ship appropriate medication(s)
- That I will be notified by the PAP if I do not meet the requirements to participate in the PAP

Without limiting the purposes for the disclosure of Information set forth above, I understand:

- That the PAP, Novo Nordisk, and others helping them will keep my Information private, but that the federal privacy laws may no longer protect my Information once it is disclosed, and that my Information may be legally redisclosed by recipients if not prohibited by state law
- That this authorization will expire 1 year from the date the patient is enrolled into the PAP
- That I may cancel this authorization at any time by giving written notice to Novo Nordisk at the address on this form, but my cancellation will not change any actions taken with my Information before canceling
- That I have the right to receive a copy of this authorization from my healthcare provider and/or Novo Nordisk, and that I may inspect/obtain a copy of the information disclosed pursuant to this authorization
- That I can refuse to sign this form, and that if I refuse to sign this form, it will not change the way that my healthcare providers, health plans, and insurers treat me
- That if I do not sign this form, I will not be able to participate in the PAP

Patient's or Patient Representative's Signature (no photocopies or power-of-attorney signature): PATIENT'S SIGNATURE	**Date:**

If signed by Patient Representative, describe relationship to patient and include documentation showing legal authority to make medical decisions for patient:

Fax all forms and other required information to: 1-866-441-4190