Patient Assistance Program Application | Rare Blood Disorders

Phone: 1-844-668-6732
Fax: 1-866-488-6576

Monday - Friday
8:00 AM to 8:00 PM ET

501 West Church Street, Suite 450
Orlando, FL 32805

novo nordisk® | NovoCare®
Savings | Coverage | Support

* Indicates a required field ☐ New Application ☐ Annual Renewal

APPLICATION INSTRUCTIONS

The **Novo Nordisk Rare Blood Disorders Patient Assistance Program (PAP)** provides medication to eligible applicants at no charge. If the applicant qualifies under the PAP guidelines, a limited supply of the requested medication(s) and applicable device(s) will be shipped to the patient. Patients who qualify for PAP will be eligible to receive shipments, as prescribed, for up to 1 year from the approval date.[a]

Select a product: ☐ NovoSeven® RT ☐ Novoeight® ☐ Tretten® ☐ Rebinyn® ☐ Esperoct®

The Novo Nordisk PAP is free. There is no registration charge or monthly fee for participating in the Novo Nordisk PAP.[b]

[a] All requests are subject to product availability and patient eligibility verification. Product limits vary.
[b] Product is provided at no cost to the patient or the HCP, is not contingent on any product purchase, and the patient and HCP must not: (1) bill any third-party for the product, or (2) resell the free product.

PRESCRIBER TO COMPLETE ALL REQUIRED FIELDS, SIGN AND DATE THE APPLICATION.
Please do not include patient medical records with this application.

PATIENT INFORMATION

Patient name:*			DOB (MM/DD/YYYY):*
Gender†:* ☐ Male ☐ Female	Preferred language: ☐ English ☐ Spanish ☐ Other:		
Home address (No P.O. box):	City:	State:	Zip:*
Shipping address (If different from Home Address):	City:	State:	Zip:*
Email:	Primary phone:	Ship drug to: ☐ Patient's home ☐ Prescribing HCP	
Primary guardian/caregiver (required if patient under 18 years old):*		Relationship to patient:	

Does your patient have any form of prescription drug coverage*? ☐ Yes ☐ No If yes, please check ALL that apply and complete information below.

Plan Name:	Member ID:	Phone:

☐ Employer-supplied or commercial/private drug coverage
☐ Medicare Part D (prescription drug coverage) (include a copy of the front and back of your card)
☐ Medicare Part B (medical benefit that covers some prescription medications)
☐ VA or Military Benefits
☐ Medicaid Prescription Drug Coverage
☐ Medicare Low Income Subsidy (LIS/Extra Help)

Not sure if your patient has Medicare Rx coverage? Medicare Part D Plan cards usually have "Medicare Rx" somewhere on the card. Medicare Advantage Plans with prescription coverage also have "Medicare Rx" somewhere on the card.

† Novo Nordisk and its partners recognize that patients may not identify as male or female. However, many insurance companies still require that one of these two fields be used for each of their members. Please indicate the gender on file with the patient's insurance company.

DIAGNOSIS

What is the primary diagnosis for which you are prescribing a Novo Nordisk factor product? *(required)**

☐ D66 - Congenital hemophilia A (without inhibitors)
☐ D66 - Congenital hemophilia A (with inhibitors)
☐ D67 - Congenital hemophilia B (without inhibitors)
☐ D67 - Congenital hemophilia B (with inhibitors)
☐ D68.2 - Other congenital factor deficiency (FVII)
☐ D68.2 - Other congenital factor deficiency (FXIII)
☐ D68.311 - Acquired hemophilia
☐ D69.1 - Qualitative platelet defect (Glanzmann's Thrombasthenia)

Other diagnosis:
ICD-10 code and description: _____

PRESCRIPTION

Order Information: Complete prescription information below or submit a prescription with the strengths and assay limits. Quantity limits apply.

Product name:	Dose:	Directions:	Qty:	Refills:

Highlights of prescribing information on following pages. For full prescribing information, see product specific package insert.

MEDICAL ASSESSMENT

Patient Weight (kg): _____

IV Access: ☐ PIV/butterfly ☐ Implanted Port ☐ PICC ☐ Central Line

Additional Information: _____

PRESCRIBER AUTHORIZATION

Prescriber name:*				License #:*
Practice name and office contact:				Preferred method of contact: ☐ Phone ☐ Fax ☐ Email
Tax ID #:	NPI #:*	Phone:*	Fax:*	Email:*
Address:*	City:*	State:*	Zip:*	

Prescriber release:* My signature certifies that I am a licensed health care practitioner eligible under state law to prescribe, receive, and dispense the requested medication(s) listed on the attached order, shipped from Novo Nordisk, and that I am not prohibited from participating in federally funded health care programs. If I am a Nurse Practitioner, Physician Assistant, Pharmacist, or PharmD, I certify that I am authorized and eligible in the state within which I am currently practicing to prescribe, receive, and dispense these products, and that I have my supervising Physician's approval to do so if required by law.

Note: Prescriber information must match prescriber's signature.

I also certify that in my medical judgment, I have determined that the product(s) detailed on the accompanying prescribing information (with only those on label indications, dosing, patient population), I am prescribing to this patient are to treat diagnosis(es) consistent with indications, dosing, and appropriate use(s) as described in the product's prescribing information.

I further certify that all information provided in this section is correct.

I agree that medication(s) provided by Novo Nordisk for the patient named in the Patient Information section will be provided by me to such eligible applicant for his or her own use without charge.

I will not otherwise use any of such medications or prescribe, provide or dispense all or any portion thereof for the use of any other person.

I consent that Novo Nordisk may contact me and/or the patient named in the Patient Information section for verification of applicant status and receipt of the indicated medication(s).

I further consent that Novo Nordisk may, at its discretion and with adequate notice, perform an on-site audit/review solely related to Novo Nordisk Patient Assistance Program (PAP) records related to the patient named above on this application.

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 towards the patient'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.

By signing below, I acknowledge that I have read and agree to the Prescriber Authorization.

Prescriber signature (no signature stamps):*	Date:*

RARE BLOOD DISORDERS | HIGHLIGHTS OF PRESCRIBING INFORMATION

Novoeight®: Hemophilia A (congenital FVIII deficiency)

Treatment type	Patient Population/Bleed type	Dose/Target factor level	Frequency
Prophylaxis	Adult (≥ 12 yrs)	20-50 IU/kg	3 times weekly
	Adult (≥ 12 yrs)	20-40 IU/kg	Every other day
	Pediatric	25-60 IU/kg	3 times weekly
	Pediatric	25-50 IU/kg	Every other day
On-demand	Minor bleed	20-40 IU/dL	Every 12-24 hours
	Moderate bleed	30-60 IU/dL	Every 12-24 hours
	Major bleed	60-100 IU/dL	Every 8-24 hours
Perioperative	Minor surgery	30-60 IU/dL	Every 24 hours
	Major surgery	80-100 IU/dL	Every 8-24 hours

Esperoct®: Hemophilia A (congenital FVIII deficiency)

Treatment type	Patient Population/Bleed type	Dose	Frequency
Prophylaxis	Adult (≥ 12 yrs)	50 IU/kg	Every 4 days*
	Pediatric (< 12 years)	65 IU/kg	2 times weekly*
On-demand	Adult: Minor bleed	40 IU/kg	1 dose should be sufficient
	Adult: Moderate bleed	40 IU/kg	An additional dose may be administered after 24 hours
	Adult: Major bleed	50 IU/kg	Additional dose(s) may be administered approximately every 24 hours
	Pediatric: any bleed	65 IU/kg	Minor: 1 dose should be sufficient
			Moderate: An additional dose may be administered after 24 hours
			Major: Additional dose(s) may be administered approximately every 24 hours
Perioperative	Adult: Minor or Major	50 IU/kg	Minor: Every 24 hours
			Major: Every 24 hours for the first week, then approximately every 48 hours until wound healing has occurred
	Pediatric: Minor or Major	65 IU/kg	Minor: Every 24 hours
			Major: Every 24 hours for the first week, then approximately every 48 hours until wound healing has occurred
*Frequency can be adjusted based on bleeding episodes			

Rebinyn®: Hemophilia B (congenital FIX deficiency); All doses/frequencies are for both adult and pediatric populations

Treatment type	Patient Population/Bleed type	Dose	Frequency
Prophylaxis	N/A	40 IU/kg	Once weekly*
On-demand	Minor/Moderate bleed	40 IU/kg	1 dose should be sufficient, but additional doses of 40 IU/kg can be given
	Major bleed	80 IU/kg	Additional doses of 40 IU/kg can be given
Perioperative	Minor surgery	40 IU/kg	1 pre-op dose should be sufficient, additional doses of 40 IU/kg can be given
	Major surgery	80 IU/kg	Pre-op dose; additional doses of 40 IU/kg can be given every 1-3 days within 1st week
*Frequency can be adjusted based on bleeding episodes and physical activity			

Tretten®: Congenital FXIII A-subunit deficiency; adult and pediatric populations

Treatment type	Patient Population/Bleed type	Dose	Frequency
Prophylaxis	N/A	35 IU/kg	Monthly*
*Consider dose adjustment if adequate coverage is not achieved			

NovoSeven® RT

Indication	Treatment type	Patient Population/Bleed type	Dose	Frequency
Hemophilia A with inhibitors or hemophilia B with inhibitors	On-demand	Adult/pediatric: all other bleeds	90 mcg/kg	Every 2 hours until hemostasis is achieved, or until the treatment has been judged to be inadequate
		Adult/pediatric: severe bleeds	90 mcg/kg	Every 2 hours until hemostasis and then post hemostatic every 3-6 hours
	Perioperative	Adult/pediatric: minor surgery	90 mcg/kg	Immediately before surgery, every 2 hours during surgery, every 2 hours after surgery for 48 hours and then every 2-6 hours until healing occurs
		Adult/pediatric: major surgery	90 mcg/kg	Immediately before surgery, every 2 hours during surgery, every 2 hours after surgery for 5 days and then every 4 hours or by continuous infusion (50 mcg/kg/hr) until healing occurs
Congenital FVII deficiency	On-demand	Adult/pediatric	15-30 mcg/kg	Every 4-6 hours until hemostasis achieved
	Perioperative	Adult/pediatric	15-30 mcg/kg	Immediately before surgery, every 4-6 hours during surgery and until healing occurs
Glanzmann's thrombasthenia (with refractoriness to platelet transfusions)	On-demand	Adult/pediatric	90 mcg/kg	Every 2-6 hours until hemostasis achieved
	Perioperative	Adult/pediatric	90 mcg/kg	Immediately before surgery, every 2 hours during surgery and every 2-6 hours post surgery
Acquired hemophilia	On-demand	Adult	70-90 mcg/kg	Every 2-3 hours until hemostasis achieved
	Perioperative	Adult	70-90 mcg/kg	Immediately before surgery, every 2-3 hours during surgery and until hemostasis achieved