Macrilen™ (macimorelin) for oral solution

If you have questions, please call 1-888-NOVO-444 (1-888-668-6444) Please fax form to 1-888-508-8200

novo nordisk®

NovoCare®
Patient Affordability and Access Support

Service and Prescription Request Form

SERVICES REQUESTED FOR MACRILEN™ (Please check all that apply)
❑ **Benefit verification:** Office will receive a summary for both the medical and pharmacy benefits, including co-pay eligibility and enrollment.
❑ **Coordination of Specialty Pharmacy fulfillment:** Upon coverage determination, your office will be notified which Specialty Pharmacy is fulfilling the prescription based on your patient's benefit plan. The Specialty Pharmacy will contact your office to coordinate shipping.

PATIENT INFORMATION			
First name:	Last name:	Middle initial:	
DOB (MM/DD/YYYY):	Address:		
Gender: ❑ Male ❑ Female	City:	State:	Zip code:
Home phone #:	Cell phone #:		

INSURANCE INFORMATION (Please attach copies of both insurance cards [primary and secondary] or provide information below)		
❑ Check here if the patient does not have insurance.		
Medical insurance company:	Member ID #:	Group ID #:
Insurance phone #:	BIN:	
Medical group (IPA):		
Pharmacy benefit plan:	Member ID #:	Group ID #:
Insurance phone #:	BIN:	
Person code #:	PCN:	

PRESCRIBER INFORMATION			
Prescriber's first name:	Prescriber's last name:		
NPI #:	Tax ID #:	Medicaid/Medicare PTAN:	
Practice name:	Phone #:		Fax #:
Practice address:	City:	State:	Zip code:
Reimbursement/Clinical contact name:		Email:	
Site of administration (select one): ❑ Physician's office ❑ Hospital outpatient ❑ Alternate site			
Shipping address (if different from practice address listed above):			
City:		State:	Zip code:

PRESCRIPTION INFORMATION			
Rx: Macrilen™ (macimorelin) for oral solution		SIG: Administer as a 1-time, single, oral dose of 0.5 mg/kg.	
❑ ICD-10/Diagnosis code: E34.9 ❑ ICD-10/Diagnosis code: E23.0 ❑ Other: _____ Patient weight: _____ kg Note: 2.2 lb=1 kg	Quantity dispensed: ❑ 1 pouch (60 mg granules) (for patients weighing ≤120 kg) ❑ 2 pouches (60 mg granules) (for patients weighing >120 kg) Refills: 0	❑ AGHDiagnose Kit Select if you would like a complimentary kit of ancillary supplies for Macrilen™ preparation to accompany this prescription.	Previous GH stimulation test(s): ❑ Insulin tolerance test (ITT) ❑ Glucagon stimulation test (GST) Please include test results if available.
Please include patient's most recent clinical notes and/or labs.			
Allergies:			❑ No known allergies
Concurrent medications:			

PRESCRIBER CERTIFICATION
My signature below certifies that the person named on this form is my patient and that I have obtained his/her written authorization in accordance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act of 1996 and its implemented regulations, to provide the individually identifiable health information on this form to reimbursement support programs and its agents, contractors, representatives, and affiliates for purposes of conducting an investigation of my patient's health insurance coverage benefits for Macrilen™. This also authorizes NovoCare® to reach out to my patient 1 time for logistics regarding the Macrilen™ test.
Prescriber's signature: _____ Date: [MM/DD/YY] _____

Return via:
Mail: NovoCare®, Attn: Patient Auth Department, PO Box 18648, Louisville, KY 40261-9907
Fax: 1-888-508-8200 **Email:** help@NovoCare.com **Online:** Register at www.NovoCare.com

NovoCare®
Patient Affordability and Access Support

Patient authorization for NovoCare® Patient Assistance Program

Patient authorization and signature

I, the patient, understand that RxCrossroads, LLC, acting on behalf of Novo Nordisk Inc. (collectively, NovoCare®), must use, share, and store my protected health information (PHI) in order to provide NovoCare® support. I hereby authorize NovoCare® to contact my health care provider, pharmacy, insurance company, or other third-party payers, and for such parties to give NovoCare® all necessary medical records and payer information, including my growth chart, medical history, clinical notes, test results, prescription drug information, and insurance information. I understand that a copy of this authorization will be provided to anyone disclosing information to NovoCare® so that it may be kept with my records. This authorization expires once I have notified NovoCare® that I have completed my growth hormone treatment (unless a shorter time period is required by state law), or unless I notify both my health care provider and NovoCare® (at fax number **1-888-508-8200**) in writing that I withdraw my approval to share my health information. My withdrawal of approval will not affect any disclosure of PHI made prior to my withdrawal.

I understand that once my health information is released to NovoCare®, it may no longer be protected by state and federal law but that NovoCare® will protect such information and use it only for the purposes stated above. I understand that NovoCare® may share my PHI with other parties in order to administer the program. I understand that I have a right to receive a copy of this authorization.

I understand that I do not have to sign the authorization form. If I choose not to sign it, my ability to obtain treatment and my eligibility for benefits under my health plan will not be affected. However, if I do not sign the authorization form, NovoCare® may not be able to provide reimbursement help or find out if I am eligible for any other NovoCare® support.

Print patient's name		Print legal representative's name	
Signature of patient	OR	Signature of legal representative (parent or guardian)	[MM/DD/YY] Date

I agree that the information I am providing may be used by Novo Nordisk, its affiliates, or vendors to keep me informed about new products, services, special offers, or other opportunities that may be of interest to me, as they become available. THESE COMMUNICATIONS MAY CONTAIN MATERIAL MARKETING OR ADVERTISING NOVO NORDISK PRODUCTS, GOODS, OR SERVICES. Novo Nordisk will take appropriate measures to protect my information. I can stop Novo Nordisk from sending me future communications by calling **1-877-744-2579**, sending a brief note with my name and address to Novo Nordisk at 800 Scudders Mill Road, Plainsboro, NJ 08536, or by clicking on the "unsubscribe" link in future email communications. By providing my information to Novo Nordisk and acknowledging below, I certify that I am at least eighteen (18) years of age.

Print patient's name		Print legal representative's name	
Signature of patient	OR	Signature of legal representative (parent or guardian)	[MM/DD/YY] Date

For more information about NovoCare® call **1-888-NOVO-444** (1-888-668-6444), between 8:00 AM and 8:00 PM ET, Monday through Friday, and visit **www.NovoCare.com**.