STATEMENT OF MEDICAL NECESSITY

☐ **New start** ☐ **Continuing treatment** ☐ **Restarting treatment** ☐ **Transitioning from**

☐ **Register patient with NovoSecure™ only**

PATIENT/INSURANCE INFORMATION

☐ Male ☐ Female Primary phone: Alternate phone:

Alternate contact name: Relationship to patient:

Address: City: State/Zip:

Email:

Primary insurance: **Pharmacy benefit insurance:**

Phone: Phone:

Subscriber name: Member ID:

Subscriber ID #: Group ID #:

Policy/group #: **Secondary insurance:**

Subscriber ID #:

Employer name: **Employer group #:**

DIAGNOSIS

What is the primary diagnosis for which you are prescribing Esperoct® [antihemophilic factor (recombinant), glycopegylated-exei]?

☐ 286.0 (D66) Congenital hemophilia A (without inhibitors)

PRESCRIPTION

Esperoct® Assays Requested

☐ 500 IU ☐ 1000 IU ☐ 1500 IU ☐ 2000 IU ☐ 3000 IU

Prophylactic Dose: **Frequency:**

Prophylaxis: Dispense doses for a duration of months

 # Refills:

Bleed Dosage: *Minor/Moderate bleed* units/kg *Major bleed* units/kg

Bleed Dosage: Dispense doses for minor/moderate bleed doses for major bleed

 # Refills:

SERVICES REQUESTED

☐ **Submit prior authorization.** If no, please provide prior authorization approval number with dates from: to: .

☐ **Interim product request**[a] (if qualified) should be received by (date). Shipping schedule to be confirmed with patient by NovoSecure™.

[a]Patients who have been prescribed a Novo Nordisk hemophilia and rare bleeding disorder product for an FDA-approved indication, and who have commercial insurance, may be eligible to receive a limited supply of free product. Patient is not eligible if he/she participates in or seeks reimbursement or submits a claim for reimbursement to any federal or state health care program with prescription drug coverage, such as Medicaid, Medicare, Medigap, VA, DOD, TRICARE, or any similar federal or state health care program. Product is provided at no cost to the patient and is not contingent on any product purchase. Physician and patient shall not: (1) bill any third party for the free product, or (2) resell the free product.

MEDICAL ASSESSMENT

Patient Height: **Patient Weight:** kg

Severity: ☐ Mild ☐ Moderate ☐ Severe **IV Access:** ☐ PIV/Butterfly ☐ Implanted Port ☐ PICC ☐ Central Line

Allergies:

Additional Clinical Information:

PHYSICIAN AUTHORIZATION

Physician name: License #:

Practice name/office contact: DEA #: Tax ID #:

Phone: Fax:

Address: City: State/Zip:

Physician release: My signature certifies that I am a licensed practitioner under state law, that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I further acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required for RxCrossroads, LLC, acting on behalf of Novo Nordisk Inc. (collectively, "NovoSecure™"), to assist in obtaining coverage for Novo Nordisk hemophilia and rare bleeding disorder products and to assist in initiating or continuing therapy. I appoint NovoSecure™, on my behalf, to convey this prescription to the dispensing pharmacy.

Physician signature (no signature stamps) **NPI #** **Date**

Note: The patient's legal guardian MUST sign and date the patient authorization on page 2.

novo nordisk®

PATIENT AUTHORIZATION
for NovoSecure™ patient support program

Patient authorization and signature

I, the patient, understand that RxCrossroads, LLC, acting on behalf of Novo Nordisk Inc. (collectively, NovoSecure™) must use, share, and store my protected health information (PHI) in order to provide NovoSecure™ support. I hereby authorize NovoSecure™ to contact my health care provider, pharmacy, insurance company, or other third-party payers, and for such parties to give NovoSecure™ 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 NovoSecure™ so that it may be kept with my records. This authorization expires once I have notified NovoSecure™ that I have completed my Novo Nordisk treatment (unless a shorter time period is required by state law), or unless I notify both my health care provider and NovoSecure™ (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 a copy of this authorization will be provided to anyone disclosing information to NovoSecure™ so that it may be kept with my records.

I understand that once my health information is released to NovoSecure™, it may no longer be protected by state and federal law but that NovoSecure™ will protect such information and use it only for the purposes stated above. I understand that NovoSecure™ 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, NovoSecure™ may not be able to provide reimbursement help or find out if I am eligible for any other NovoSecure™ support.

Print patient's name		Print legal representative's name	
	OR		
Signature of patient		**Signature of legal representative**	**Date**

If you would like to enroll in NovoSecure™ please sign below

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	
	OR		
Signature of patient		**Signature of legal representative**	**Date**