

* Indicates a required field New start Reauthorization Restarting treatment Transitioning from: _____

SERVICES REQUESTED	Access Support Requested:
	<input type="checkbox"/> Prior Authorization support request. If PA approved, provide PA approval number _____ with dates from: _____ to: _____.
	<input type="checkbox"/> Appeals support request
	Additional Services:
<input type="checkbox"/> JumpStart [™] request	
<input type="checkbox"/> Norditropin [®] FlexPro [®] Device Training: <input type="checkbox"/> In-person <input type="checkbox"/> Virtual	
<input type="checkbox"/> Starter Kit	
<input type="checkbox"/> NovoCare [®] Savings Offer (if eligible). For complete terms and conditions, visit norditropinsavings.com .	
^a Terms and conditions of JumpStart [™] require active, timely prescriber support of Prior Authorization and/or Appeal documentation submission.	
^b Patients who have been prescribed Norditropin [®] for an FDA-approved indication and who have commercial insurance may be eligible to receive a limited supply of free product from JumpStart [™] . 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. JumpStart [™] 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 free product, or (2) resell the free product. No purchase necessary.	

PATIENT/INSURANCE INFORMATION	Patient first name: *	Patient last name: *	DOB (MM/DD/YYYY): *	
	Gender: * <input type="checkbox"/> Male <input type="checkbox"/> Female Preferred language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			
	Shipping address 1 (No P.O. box):		Shipping address 2:	
	City:	State:	Zip:	Email:
	Primary phone:	Alternate contact name:	Relationship to patient:	
	Primary medical insurance: (Please attach a copy of the insurance card if available)			Phone:
	Subscriber name:	Subscriber ID:	Policy/group #:	
	Secondary medical insurance:			Phone:
	Subscriber name:	Subscriber ID:	Policy/group #:	
	Primary pharmacy insurance: (Please attach a copy of the insurance card if available)			Phone:
Rx # ID:	Rx Group #:	Rx PCN #:	Rx BIN #:	
[†] 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	Adult GHD: (required)*	Due to: (required)*
	<input type="checkbox"/> Childhood onset <input type="checkbox"/> Adult onset	<input type="checkbox"/> E23.0 - Hypopituitarism <input type="checkbox"/> E23.1 - Drug-induced hypopituitarism <input type="checkbox"/> E89.3 - Postprocedural hypopituitarism
	Other diagnosis: ICD-10 code and description: _____	

PRESCRIPTION	If requesting JumpStart[™] please select both Prescription fields (required)* <input type="checkbox"/> JumpStart[™] Prescription <input type="checkbox"/> Ongoing Prescription		
	Norditropin [®] (somatropin) FlexPro [®] prefilled pen: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg <input type="checkbox"/> 30mg	NovoFine [®] Needles: <input type="checkbox"/> 32G Tip (6mm) disposable needles <input type="checkbox"/> PenMate [®] reusable cover for needles: <input type="checkbox"/> Autocover [®] 30G (8mm) disposable safety needles <input type="checkbox"/> 1 <input type="checkbox"/> 2	
	Directions: Inject _____ mg SC daily _____ days per week _____ Days Supply _____ Refills		
	Preferred pharmacy:	Pharmacy Phone:	Pharmacy Fax:
	Pharmacy address:	City:	State: Zip:

MEDICAL ASSESSMENT	Initial GH Stimulation Testing for CO-GHD; please include copies of test results if available			
	GH stim test 1	GH stim test 2	IGF-1 #1: _____	MRI has been completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date: ____/____/____	Date: ____/____/____	IGF-1 #2: _____	Date of MRI: ____/____/____
	Agent: _____	Agent: _____	Results: _____	
	Results: _____	Results: _____		

PRESCRIBER AUTHORIZATION	Prescriber name: *	License #: *
	Practice name:	Office contact:
	DEA #:	Tax ID #:
	Phone: *	Fax: *
	Address: *	City: *
	State: *	Zip: *
	Prescriber release: * By signing below, I hereby certify that: (a) I am a licensed practitioner, in good standing under applicable state law; (b) the product being prescribed is to treat a diagnosis(es) consistent with indications and dosing described in the product's prescribing information; (c) the information I have provided on this enrollment form is, to the best of my knowledge, true, complete, and accurate in all respects; and (d) I have obtained the necessary authorization from the patient, or where appropriate the patient's parent, caregiver, and/or legal representative to use, disclose, share, and/or release the above-referenced information along with other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) for the sole purpose of providing patient assistance. Further, I appoint NovoCare [®] , on my behalf, to convey this prescription to the dispensing pharmacy. I will immediately notify Novo Nordisk Inc., its employees, or partners, including AssistRx, Inc. (collectively, "NovoCare [®] ") if the above-named patient, or where appropriate the patient's parent, caregiver, and/or legal representative, revokes their consent to share their PHI with NovoCare [®] . I give you permission to contact me, or the above named patient/Caregiver, with any questions related to NovoCare [®] .	
Prescriber signature (no signature stamps):*	Date: *	