



The Novo Nordisk Minnesota State Insulin Affordability Program provides medication to qualifying applicants at no charge. If the applicant qualifies under the Minnesota State guidelines, up to a 120-day supply of the requested medication(s) or device(s) will be shipped to the patient.

Eligibility Requirements

You may qualify if:

- You are a resident of Minnesota and can provide one of the following:
 - Valid Minnesota driver's license or permit
 - Valid Minnesota identification card
 - Valid tribal identification card from a Minnesota tribeor
 - If the person who needs insulin is under the age of 18, the parent or legal guardian must provide proof of residency
- You are not enrolled in Medicaid or low-cost health insurance sponsored by the state (Minnesota Cares)
- You are not eligible to receive prescription drug benefits through federally funded programs, with the exception of Medicare Part D
- You are not enrolled or eligible to receive prescription drug benefits through the Department of Veterans Affairs
- If you have private prescription drug coverage, your out-of-pocket cost for a 30-day supply of insulin is greater than \$75
- Your total household income is at or below **400%** of the federal poverty level (FPL) ([NeedyMeds website](#) lists current FPL guidelines)

What to send?

- Completed application ([signed and dated by both patient and prescriber](#))
- Proof of income
- Copy of Minnesota driver's license or permit/identification card/Tribal card

IMPORTANT

- Sign and Date **ALL** applicable sections.
- Ensure **ALL** *required fields have been completed.
- Include **ALL** required supporting documentation.
- Mail/Fax completed application & copies of required income documentation.

Any missing/incomplete/illegible information may cause a delay in processing.

Questions?

Phone: 866-310-7549 Monday-Friday 8AM-8PM ET

Fax: 866-441-4190

Patients: [NovoPAP.com](#) HCPs: [NovoPAPHCP.com](#)

What to Expect Next?

- Mail/Fax completed application & required income documentation.
 - Allow 2 business days for processing.
 - Enrollment decision will be sent via mail/fax to patients and healthcare providers.
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- Once approved, patients will receive a phone call to schedule delivery of medication to their home.
 - Approved uninsured patients will be enrolled for 12 months. Medicare Part D patients are enrolled through the end of the calendar year and will need to reapply after October 15th for the following year.



Check one: New Application
 Re-Enrollment

Asterisks indicate required field. Do not leave blank.

PATIENT SECTION

Patient First Name*:	Last Name*:	Patient DOB*:
Patient's Street Address* (NO PO BOX): City: State: Zip: Note: MN residents who qualify for insulin under state insulin safety net laws will have their medication shipped directly to their home		
Home Phone*:	Mobile Phone*:	
Gender: Male Female Prefer not to disclose	Email:	
Patient Authorized Representative (Optional)		
Name:	Relationship:	
Patient /Authorized Representative Signature (if under 18 or unable to sign, parent, guardian or authorized representative signature required):		
	Date:	
You may provide the names of one or more individuals whom you authorize the Novo Nordisk State Insulin Program ("Program") to speak with on your behalf about your application, the status of your shipment of medication, or your participation in the Program. Those people who you authorize to speak to the Program about you may provide or receive your personal information as necessary. Novo Nordisk does not accept paid advocacy groups as a patient-authorized representative. The Program is not affiliated with third parties who charge a fee for help with enrollment. These third parties may reference Novo Nordisk without permission. Patients are not required to use a third party who charges a fee to help with enrollment or refills. To remove an authorized representative, please call the Program at 1-866-310-7549		

Insurance

Do you have any form of prescription drug coverage *? If YES , please check ALL that apply and complete information below.	YES	NO
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 you have 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.		

Income (include proof of income with application)

Total Household Annual Income \$	
# of people living in your household* (include yourself, spouse/partner, all adults)	# of dependents (under 18 years of age)*
Include a copy of one of the following with your application *: (NOTE: Please provide proof of income for ALL members of the household.)	
2 most current consecutive pay stubs or earning statements for all working members of the household	Retirement benefit statement (within 12 months) Last year's Federal Income Tax Return (1040, 1040X)
Social Security Income, pension and other income statements, including interest or dividend statements	W-2, 1099 (SSA, R, INT, DIV) Statement of Zero Income (if applicable)
Unemployment benefit statement/Worker's Compensation	Pension benefit statement (within 12 months)

Patient Medicare Part D Enrollee Consent (if applicable)

I (or my parent/guardian/legal representative) agree that if I am (or the patient is) approved for the Program as a Medicare Part D Enrollee, that Novo Nordisk or the Program may give my (or the patient's) Personal Information to the Centers for Medicare & Medicaid Services ("CMS") to confirm my (or the patient's) Medicare Part D enrollment status and let CMS and my (or the patient's) Medicare Part D plan know of this enrollment in the Program. Further, I (or my parent/guardian/legal representative) understand that upon approval, I (or the patient) will receive up to a 120-day supply of the medication(s) and/or device(s) from the Program through the end of this calendar year. I (or my parent/guardian/legal representative) agree that I (or the patient): (i) will not seek the requested Novo Nordisk medication(s) from my (or the patient's) Medicare Part D prescription plan while receiving them from the Program; (ii) am not eligible for reimbursement for any medication dispensed by the Program from any government program or third-party insurer; and (iii) and will not apply any medication(s) received through the Program toward my (the patient's) True-Out-of-Pocket ("TrOOP") costs.	
Signature required ONLY if patient is a Medicare Part D enrollee	Member Number/ID#*:
Patient or Parent/Guardian/Legal Representative Signature:	
Application Enrollment Year:	Date:

Fiasp®, FlexPen®, FlexTouch®, GlucaGen®, HypoKit®, Levemir®, NovoFine®, NovoFine® Plus, Novolin®, NovoLog®, NovoPen Echo®, PenFill®, and Tresiba® are registered trademarks of Novo Nordisk A/S. Novo Nordisk is a registered trademark of Novo Nordisk A/S.



Asterisks indicate required field. Do not leave blank.

PATIENT SECTION (continued)

Patient Information

Patient First Name*:	Last Name*:	Patient DOB*:
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Patient or Parent/Guardian/Legal Representative Authorization

By signing below, I (or my parent/guardian/legal representative) hereby give permission for my (or the patient's) health care providers, pharmacies, service providers and their contractors, health plans, and health insurer(s) and their contractors, to disclose any and all necessary information, including, but not limited to, my (or the patient's) income, prescription coverage, medical prescriptions, medical condition, financial documents, and health records ("Personal Information") to the Novo Nordisk State Insulin Program ("Program").

This Personal Information aids the Program in administering the Program by: (i) processing this Application; (ii) verifying my information; (iii) identifying and/or determining eligibility under the Program and other patient assistance resources; (iv) investigating and verifying my insurance benefits; (v) coordinating the dispensing and delivery of medication; (vi) conducting additional services to run the Program; and (vii) conducting quality assurance and/or other internal business activities in connection with the Program.

I (or my parent/guardian/legal representative) further give permission to the Program to use and disclose my (or the patient's) Personal Information to Health Care Providers, Insurer(s), caregivers, Novo Nordisk, its affiliates, service providers, and agents (collectively "Novo Nordisk"), for the purposes described above.

I (or my parent/guardian/legal representative) understand and acknowledge that while the Program, Novo Nordisk, and any authorized contractors acting on their behalf will make every effort to keep Personal Information private once Personal Information is disclosed it may no longer be protected by federal privacy and security laws or applicable state laws. Specifically, I (or my parent/guardian/legal representative) acknowledge that once disclosed, Personal Information may be legally re-disclosed by authorized recipients unless otherwise prohibited by law.

I (or my parent/guardian/legal representative) understand that this authorization may be refused. I (or my parent/guardian/legal representative) may also revoke (withdraw) this authorization at any time in the future by calling 1-866-310-7549 or writing to Novo Nordisk, Inc. PO Box 370, Somerville, NJ 08876. Such refusal or future revocation will not affect my (or the patient's) commencement or continuation of treatment by healthcare providers, pharmacies, service providers, insurer(s), etc. **However, if I (or my parent/guardian/legal representative) revoke this authorization, there can be no further participation in the Program and/or services administered by the Program.**

If I (or my parent/guardian/legal representative) revoke this authorization, the Program will stop using or sharing my (or the patient's) Personal Information (except as necessary to end participation) but such revocation will not affect uses and disclosures of Personal Information previously disclosed in reliance upon this authorization. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may receive a copy of this authorization which will remain valid for one (1) year after the date of my signature unless revoked earlier. I (or my parent/guardian/legal representative) also understand that the Program may change or end at any time without prior notification.

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

Patient Name (print)*:	Date*:
Parent/Guardian/Legal Representative Name (if applicable)*:	
Relationship to patient (if applicable)*:	Phone*:
Patient or Parent/Guardian/Legal Representative Signature*:	

Telephone Consumer Protection Act ("TCPA") Communication Consent

I (or my parent/guardian/legal representative) also agree to be contacted by the Program and others on its behalf by telephone calls made by or using an automated dialing system or pre-recorded messages at the number(s) provided in this Application, for all non-marketing purposes. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may be asked to provide my (or the patient's) zip code and date of birth during pre-recorded calls in order to verify my (or the patient's) identity and that this information will not be retained by the Program or its partners but is simply to verify identity. I (or my parent/guardian/legal representative) agree to notify the Program promptly if any of my numbers or addresses change in the future. I (or my parent/guardian/legal representative) understand that this consent is not required, or a condition of purchase and it can be revoked at any time. I (or my parent/guardian/legal representative) further understand that I (or my parent/guardian/legal representative) can review the full Novo Nordisk Privacy Policy at <https://www.novonordisk-us.com/privacy-notice.html>.

By providing a phone number and signing below, I acknowledge that I have read and agree to the TCPA Communication Consent above.

Phone*:

Safety Information

If a safety concern is reported, I (or my parent/guardian/legal representative) give permission to share my personal information to Novo Nordisk, who may contact me with follow-up inquiries, and who may report my personal information to the health authorities to comply with applicable rules and regulations.

Patient or Parent/Guardian/Legal Representative Authorization & Certification

I (or my parent/guardian/legal representative) hereby certify that I (or my parent/guardian/legal representative): (i) am over 18; (ii) do not have the ability to pay for the medication(s) requested by my (or the patient's) health care provider on the attached prescription(s); (iii) am not enrolled in or eligible for Medicaid or Medicare Extra Help/Low Income Subsidy ("LIS"); (iv) all information provided in this application is true and correct and that I (or my parent/guardian/legal representative) will verify any of the information provided to the Program upon request; (v) will verify my (or the patient's) Application status and receipt of the indicated medication(s) upon request by the Program; (vi) if approved to participate in the Program, I (or my parent/guardian/legal representative) will not seek reimbursement for the medication(s) requested from any government program or third-party insurer; (vii) will comply with any insurance carrier disclosure requirements, including my participation in the Program.

I (or my parent/guardian/legal representative) understand and agree: (i) my eligibility to participate in the Program is subject to Novo Nordisk's decision and that Novo Nordisk may modify or terminate the Program at any time; (ii) I may be required to provide proof of ineligibility for certain other prescription drug coverage programs in order to meet the eligibility requirements for the Program; and (iii) I am required to report any changes to my health insurance and prescription drug coverage to the Program. I (or my parent/guardian/legal representative) understands that the product received through the Program is provided to me free of charge and that I have no obligation to purchase the Product due to my participation in the Program. I (or my parent/guardian/legal representative) also give permission to the Program to combine or aggregate any information collected about me with information the Program may collect from other sources for the purpose of providing or administering the Program.

In completing this Application, I confirm the following is complete and accurate and that I have read and agree to the Patient Authorization.

Patient Name (print)*:	Date*:
Parent/Guardian/Legal Representative Name (if applicable)*:	
Relationship to patient (if applicable)*:	Phone*:
Patient or Parent/Guardian/Legal Representative Signature*:	



Asterisks indicate required field. Do not leave blank.

PRESCRIBER SECTION

Patient First Name*:	Last Name*:	Patient DOB*:
Other Medications*:	Known Drug Allergies*:	

Prescriber Information

First Name*:	Last Name*:	Designation*:
Street Address* (Include Suite/Building#):		
(NO PO BOX) City:	State:	Zip:
Phone*:	State License Number#*:	State Where Licensed:
Fax*:	Office Contact:	Email:
		NPI*:

By signing below, I acknowledge that I have read and agree to the Health Care Practitioner Declaration.

Health Care Practitioner Declaration: "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: Prescribing practitioner information must match the practitioner's signature.** I also certify that the product(s) being prescribed are to treat diagnosis(es) consistent with indication(s) and dosing described in the product's prescribing information. I further certify that all information provided in the Licensed Health Care Practitioner Information section is correct. I agree that medication(s) provided to me by Novo Nordisk for the applicant named in the Applicant 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 the applicant named in the Applicant 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 State Insulin Program (the "Program") records related to the applicant named above on this application. I understand that I am not eligible to seek reimbursement for any medication dispensed by the Program, from any government program or third-party insurer and will not apply any Novo Nordisk medication, provided by the Program, towards the applicant's True-Out-Of-Pocket (TrOOP) costs. I also understand that eligibility under the Program is subject to Novo Nordisk's discretion and that Novo Nordisk reserves the right to modify or terminate the Program at any time. Finally, I certify that I receive no direct or indirect payments related to the Program."

Practitioner's Signature*:

Date*:

Products are dispensed as written. (Handwritten/valid electronic signatures accepted; no photocopies, power or attorney, or stamped signatures allowed)

Rx

Product	Max Dose/Day (units)	Sig/Directions (e.g., QD, BID)	Formulation	Quantity
Fiasp® (insulin aspart injection) 100 U/mL			Vial FlexTouch® Cartridge	
Tresiba® (insulin degludec) injection U-100			Vial FlexTouch®	
Tresiba® (insulin degludec) injection U-200			FlexTouch®	
Levemir® (insulin detemir) injection 100 U/mL			Vial FlexTouch®	
NovoLog® (insulin aspart) injection 100 U/mL			Vial FlexPen® Cartridge	
Insulin Aspart Injection 100 U/mL (UB)			Vial FlexPen® Cartridge	
NovoLog® Mix 70/30 (insulin aspart protamine and insulin aspart injectable suspension) 100 U/mL			Vial FlexPen®	
Insulin Aspart Protamine and Insulin Aspart Injectable Suspension Mix 70/30 100 U/mL (UB)			Vial FlexPen®	
Novolin® R (insulin human injection) 100 U/mL			Vial	
Novolin® N (isophane insulin human suspension) 100 U/mL			Vial	
Novolin® 70/30 (human insulin isophane suspension and human insulin injection) 100 U/mL			Vial	
NovoFine® 32G (100 needles/box)				
NovoFine® Plus 32G (100 needles/box)				
GlucaGen® HypoKit® (glucagon for injection) 1 mg/mL			1 kit	
NovoPen Echo®			1 pen	

All orders will be filled with up to a **120-day** supply unless otherwise indicated by the prescriber. Prescribers, please complete the application with max daily dose and sig accordingly.
FlexPen®/FlexTouch® is used with Novo Nordisk disposable needles. **Needles will not be sent as part of the Program order if they are not requested.**

UB=Unbranded Biologic. Unbranded Biologics of Novo Nordisk-branded analog insulins are available from Novo Nordisk Pharma, Inc. (NNPI)