Patient Section

Novo Nordisk
Minnesota State Insulin Affordability Program

The Novo Nordisk Patient Assistance Program (PAP) provides medication at no charge to applicants who qualify under the PAP guidelines. Requested medications or devices will be shipped directly to you, up to a 120-day supply.

The Novo Nordisk PAP is free. There is no registration charge or monthly fee for participating in the Novo Nordisk PAP. All requests are subject to product availability and patient eligibility verification. Product is provided at no cost to the patient or the HCP, is not contingent on any product purchase, and the patient and HCP agree to not bill any third party for the product nor resell the product.

There will be a delay in processing unless each section of this form is fully completed. Please print legibly.

Check one: ☐ **New Application** ☐ **Re-Enrollment** ***Asterisks indicate required field. Do not leave blank.**

SECTION A

Patient First Name*:	Patient Last Name*:	
Patient Street Address* (NO PO BOX):		
City*:	State*:	ZIP*:
Phone*:	Email:	
DOB*:	Gender: ☐ Male ☐ Female ☐ Prefer not to disclose	
Prescriber First Name*:	Prescriber Last Name*:	
Prescriber Phone*:		

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

- ☐ Medicare (Part D) Prescription Coverage - ***must complete Section B***
- ☐ 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)
- ☐ Employer-supplied or commercial/private drug coverage

You may qualify if you are not enrolled in Medicaid or low-cost health insurance sponsored by the State (Minnesota Cares), or if you have private prescription drug coverage, your out-of-pocket cost for a 30-day supply of insulin is greater than $75.

Medicare Part D Enrollees – MUST COMPLETE ALL OF SECTION B

Not sure if you have Medicare Rx coverage? Do you have both commercial insurance and Medicare? Call the Benefits Coordination & Recovery Center toll-free at 1-855-798-2627 with questions about your benefits. 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.

SECTION B

Patient Medicare Prescription Drug Coverage (Part D) Enrollee Consent (if applicable)

I (or my parent/guardian/legal representative) agree that if I am (or the patient is) approved for PAP as a Medicare Part D Enrollee, Novo Nordisk or PAP 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 PAP. 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 PAP 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 PAP; (ii) am not eligible for reimbursement for any medication dispensed by PAP from any government program or third-party insurer; and (iii) and will not apply any PAP medication(s) toward my (the patient's) True-Out-of-Pocket ("TrOOP") costs.

Patient or Representative Signature*: Required ONLY if patient is a Medicare Part D enrollee	Date*:
PAP Application Enrollment Year:	Member ID*:

Phone: 866-310-7549 M–F 8am–8pm ET Novo Nordisk, Inc. PO Box 370 Somerville, NJ 08876 **Fax: 866-441-4190**

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Patient Section

Novo Nordisk
Minnesota State Insulin Affordability Program

*Asterisks indicate required field. Do not leave blank.

First Name*:	Last Name*:	DOB*:

SECTION C

Income Verification Consent [Fair Credit Reporting Act (FCRA)] *REQUIRED:
BOTH CHECK BOX AND SIGNATURE ARE REQUIRED

PAP will perform an electronic income verification to process your application on your behalf.
Please check box to provide consent.

☐ I understand that I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA"), authorizing PAP, Novo Nordisk, and its authorized vendor(s), on an ongoing basis as needed for the duration of my participation in programs administered by Novo Nordisk PAP, to obtain information from my credit profile or other information from the vendor through e-income verification which will include a soft credit check, solely for the purpose of determining financial qualifications for programs administered by PAP. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide, is complete and true. I also understand that I may need to provide additional documentation and that additional eligibility requirements apply for the Novo Nordisk PAP.

Patient Signature*:

SECTION D

Consent to Collection of Health Information for PAP Purposes *REQUIRED
BOTH CHECK BOX AND SIGNATURE ARE REQUIRED

I (or my parent/guardian/legal representative) agree that Novo Nordisk and its data processors may collect, use, and disclose my (the patient's) health-related information, as described below (collectively, "Health Information") for participation in PAP:

- Individual health conditions, treatment, diseases, or diagnosis; Use or purchase of prescribed medication; Bodily functions, vital signs, symptoms, or measurements related to health; Diagnoses or diagnostic testing, treatment, or medication; Data that identifies a Consumer seeking health care services; Health-related data that have been derived or inferred from the above.
- We also collect any health-related information you disclose if you contact us, including information regarding adverse events.

If I consent below, Novo Nordisk and its data processors will collect, use, and disclose my Health Information solely to facilitate my participation in PAP, including by way of example, dispensing pharmacies, income verification, and electronic benefit checks (the "Purposes") among other PAP-related Purposes. I understand that I (or my parent/guardian/legal representative) am not required to consent to processing of my Health Information for the Purposes. However, if I do not consent, I will not be able to participate in PAP, as collection of my Health Information is necessary for Novo Nordisk to facilitate my participation. If I consent below, I have the right to withdraw consent at any time and may do so by emailing NNIPrivacy@novonordisk.com. For more information regarding our processing of personal information and Health Information, please see our Privacy Notice and our Consumer Health Data Privacy Notice.

You must select one of the boxes below.*

☐ I consent or [I consent on behalf of the patient, and I hereby affirm that I have the legal right to do so, that I am parent or legal guardian of the patient, or that I otherwise have valid power of attorney to act on behalf of the patient.]

☐ I do not consent or [I do not consent on behalf of the patient, and I hereby affirm that I have the legal right to do so, that I am parent or legal guardian of the patient, or that I otherwise have valid power of attorney to act on behalf of the patient.]

Patient or Representative Signature*:	Date*:
Legal Representative:	
Relationship to patient:	
Phone:	

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Patient Section

Novo Nordisk
Minnesota State Insulin Affordability Program

*Asterisks indicate required field. Do not leave blank.

First Name*:	Last Name*:	DOB*:

SECTION E

HIPAA Authorization *REQUIRED

BOTH CHECK BOX AND SIGNATURE ARE REQUIRED

☐ 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's Patient Assistance Program (collectively, "PAP"). This Personal Information aids PAP in administering PAP by: (i) processing this Application; (ii) verifying my information; (iii) identifying and/or determining eligibility under PAP 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 PAP; and (vii) conducting quality assurance and/or other internal business activities in connection with PAP. I (or my parent/guardian/legal representative) further give permission to PAP to use and disclose my (or the patient's) Personal Information to Health Care Providers, Insurer(s), and caregivers, and to 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 PAP, 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 health care providers, pharmacies, service providers, insurer(s), etc. However, if I (or my parent/guardian/legal representative) refuse to sign or revoke this authorization, there can be no further participation in the programs and/ or services administered by PAP. If I (or my parent/guardian/legal representative) revoke this authorization, PAP will stop using or sharing disclosing 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 PAP 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 or Representative Signature*:	Date*:

☐ I am signing on behalf of the patient, and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have valid power of attorney to act on behalf of the patient.

Legal Representative:

Relationship to patient:

Phone:

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*Asterisks indicate required field. Do not leave blank.

First Name*:	Last Name*:	DOB*:

SECTION F

Patient Authorized Representative (please select one)

You may provide the name of an individual (ie, spouse, sibling, child, etc.) whom you authorize the Novo Nordisk Patient Assistance Program to speak with on your behalf about your participation in the Novo Nordisk PAP. Those people who you authorize to speak to Novo Nordisk PAP about you may provide or receive your personal information as necessary. Novo Nordisk does not accept paid advocacy groups as a patient-authorized representative. Novo Nordisk PAP 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.

☐ **Yes, I would like to authorize a person to speak on my behalf.**

☐ **No, I do not want anyone speaking to Novo Nordisk PAP on my behalf.**

If yes, please provide name, phone number, and relationship below.

Authorized Representative Name:	Authorized Representative phone number:
☐ Family member/caregiver	☐ Other
Patient Signature:	Date:

To remove an authorized representative, please call Novo Nordisk PAP at 1-866-310-7549.

SECTION G

Telephone Consumer Protection Act ("TCPA") Communication Consent

BOTH CHECK BOX AND SIGNATURE ARE REQUIRED

☐ I (or my parent/guardian/legal representative) also agree to be contacted by PAP 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, to facilitate my participation in PAP 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 PAP or its partners but is simply to verify identity. I (or my parent/guardian/legal representative) agree to notify PAP promptly if any of my numbers or addresses change in the future. I (or my parent/guardian/ legal representative) understand that I can revoke this consent 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. I (OR MY PARENT/GUARDIAN/LEGAL REPRESENTATIVE) UNDERSTAND THAT ANY CALLS MAY BE GENERATED USING AN AUTOMATED DIALING SYSTEM OR PRE-RECORDED MESSAGES, AND I DO NOT HAVE TO CONSENT TO RECEIVE CALLS BEFORE PURCHASING GOODS OR RECEIVING OTHER SERVICES FROM NOVO NORDISK. By providing a phone number and signing below, I acknowledge that I have read and agree to the TCPA Communication Consent above.

Patient Signature*:

Phone:

SECTION H

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.

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Patient Section

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Minnesota State Insulin Affordability Program

*Asterisks indicate required field. Do not leave blank.

First Name*:	Last Name*:	DOB*:

SECTION I

Program Authorization & Certification *REQUIRED

Novo Nordisk Patient Assistance Program (PAP) Authorization (only needed if patient is applying to PAP)
I (or my parent/guardian/legal representative) hereby certify that I (or my parent/guardian/legal representative): (i) am over 18; (ii) am a United States citizen or legal resident; (iii) 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) and I meet the financial criteria detailed on this application to qualify for the program. I also certify that I am not enrolled in or eligible for any of the following: (i) Medicaid; (ii) Medicare Extra Help/Low Income Subsidy ("LIS"); (iii) federally funded insurance programs, with the exception of Medicare Part D; or (iv) receive prescription drug benefits throughout the U.S. Veterans Administration, other than Medicare Part D. Patients enrolled in Medicare Part D who satisfy the financial eligibility criteria qualify for the program, but once enrolled, must stay in the program through the end of the calendar year. I certify that (i) 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 PAP upon request; (ii) will verify my (or the patient's) application status and receipt of the indicated medication(s) upon request by PAP; (iii) if approved to participate in PAP, I (or my parent/guardian/legal representative) will not seek reimbursement for the medication(s) requested from any government program or third-party insurer; and (iv) will comply with any insurance carrier disclosure requirements, including my participation in PAP; (v) I (or my parent/guardian/legal representative) authorize PAP to contact me (or my parent/guardian/legal representative) by mail, email, and telephone (in accordance with the TCPA Communication Consent above) at the number(s), email(s), and address(es) provided on this application so that PAP can provide me with access to the products which I am prescribed. I (or my parent/guardian/legal representative) understand and agree: (i) my eligibility to participate in PAP is subject to Novo Nordisk's decision and that Novo Nordisk may modify or terminate PAP 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 PAP; and (iii) I am required to report any changes to my health insurance and prescription drug coverage to PAP. I (or my parent/guardian/legal representative) understands that the product received through the PAP is provided to me free of charge and that I have no obligation to purchase the product due to my participation in the PAP. I (or my parent/guardian/legal representative) also give permission to PAP to combine or aggregate any information collected about me with information PAP may collect from other sources for the purpose of providing or administering PAP. In completing this Application, I confirm the following is complete and accurate and that I have read and agree to the Patient Authorization.

Patient or Representative Signature*:	Date*:

☐ I consent on behalf of the patient, and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have valid power of attorney to act on behalf of the patient.

Legal Representative:

Relationship to patient:

Phone:

PROOF OF MINNESOTA RESIDENCY REQUIRED

Proof of Residency is required. Accepted forms include:

- Valid Driver's License/Permit
- Valid Identification Card
- Valid Tribal Identification Card from a Minnesota Tribe

If the person who needs insulin is under the age of 18, the parent or legal guardian must provide proof of residency.
Please attach when submitting the form.

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An incomplete application will delay your decision.
Make sure you have completed the following checklist:

- ☐ Answer each question in section A, and do not leave blanks. This includes your insurance information.
- ☐ Be sure to write your name and DOB at the top of each page.
- ☐ If you have Medicare Prescription Drug Coverage (Part D), you must complete all required fields in section B.
- ☐ Make sure to check section C, as this information is required to process your application. If checked, you do not need to submit proof of income.
- ☐ Sign and date the HIPAA authorization in section E.
- ☐ If you wish to authorize anyone to speak with the Novo Nordisk Patient Assistance Program (PAP) on your behalf, answer each question of section F.
- ☐ If you would like to be contacted by phone, check the box in section G for future communications.
- ☐ Complete each question in section I.
- ☐ Must include PROOF OF RESIDENCY. See bottom of page 5 for approved forms.

What to Expect Next:

You take your completed form to your health care provider, or you can mail or fax the patient portion of the completed application directly to the Novo Nordisk Patient Assistance Program (PAP). See the bottom of the page for fax number and address.

Once received by the Novo Nordisk Patient Assistance Program (PAP), allow at least **2 business days** for processing.

Your enrollment decision will be sent to you via mail after processing time.

If you opted to receive prerecorded phone calls, you will also receive enrollment decisions via phone.

Once approved, your prescription will be sent to CoverMyMeds Pharmacy. Once received, you will then receive a phone call from CoverMyMeds Pharmacy to schedule your shipment. Please save CoverMyMeds phone number (877-266-6479) to your contacts so you do not miss the call.

Phone: 866-310-7549 M–F 8am–8pm ET Novo Nordisk, Inc. PO Box 370 Somerville, NJ 08876 **Fax: 866-441-4190**

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Minnesota State Insulin Affordability Program

***Asterisks indicate required field. Do not leave blank.**

SECTION J

Patient First Name*:	Patient Last Name*:	DOB*:
Known Drug Allergies*:		
Patient Street Address*:		
City*:	State*:	ZIP*:
Patient Email:		

SECTION K

Prescriber Information (Insulin products will be shipped to the patient's address. **No PO Box permitted.**)			
Prescriber First Name*:	Prescriber Last Name*:	Designation:	
Street Address*:			
Suite/Building/Floor#:	City*:	State*:	ZIP*:
Phone*:	State License Number#*:	State Where Licensed:	
Fax*:	Office Contact:	Office Email:	
NPI*:	Days Office is Closed for Deliveries:		

SECTION L

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 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 Patient Assistance Program (PAP) 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 PAP, from any government program or third-party insurer and will not apply any Novo Nordisk medication, provided by PAP, towards the applicant's True-Out-Of-Pocket (TrOOP) costs. I also understand that eligibility under PAP is subject to Novo Nordisk's discretion and that Novo Nordisk reserves the right to modify or terminate PAP at any time. Finally, I certify that I receive no direct or indirect payments related to PAP."

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Prescriber Section

Novo Nordisk
Minnesota State Insulin Affordability Program

*Asterisks indicate required field. Do not leave blank.

Patient First Name*:	Patient Last Name*:	DOB*:
Prescriber First Name*:	Prescriber Last Name*:	NPI*:

Product*	Max Dose/Day (units)	Sig/Directions*	Formulation* Cart = Cartridge	Qty
Insulin				
Tresiba® (insulin degludec) injection U-100			☐ Vial ☐ FlexTouch®	
Insulin Degludec Injection U-100 (UB)			☐ Vial ☐ FlexTouch®	
Tresiba® (insulin degludec) injection U-200			☐ FlexTouch®	
Insulin Degludec Injection U-200 (UB)			☐ FlexTouch®	
Fiasp® (insulin aspart) injection 100 U/mL			☐ Vial ☐ FlexPen® ☐ Cart	
NovoLog® (insulin aspart) injection 100 U/mL			☐ Vial ☐ FlexPen® ☐ Cart	
Insulin Aspart Injection 100 U/mL **(UB)**			☐ Vial ☐ FlexPen® ☐ Cart	
Novolin® R (insulin human) injection 100 U/mL			☐ Vial	
Novolin® N (insulin isophane human) injectable suspension 100 U/mL			☐ Vial	
NovoPen Echo®		☐ 1 pen		
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® 70/30 (insulin isophane human and insulin human) injectionable suspension 100 U/mL			☐ Vial	
Other				
Zegalogue® (dasiglucagon) injection 0.6 mg/0.6 mL		☐ Auto-injector 1-pack ☐ Prefilled Syringe 1-pack	☐ Auto-injector 2-pack ☐ Prefilled Syringe 2-pack	
Needles				
NovoFine® 32G 6mm (100 needles/box)				

FlexPen®/FlexTouch® are used with Novo Nordisk disposable needles. **Needles will not be sent as part of the PAP order if they are not requested.**

By signing below, I acknowledge that I have read and agree to the Health Care Practitioner Declaration on page 7. Products are dispensed as written. (Handwritten/valid electronic signatures accepted; no photocopies, power of attorney, or stamped signatures allowed.)

Practitioner Signature*: Date*:

Phone: 866-310-7549 M–F 8am–8pm ET Novo Nordisk, Inc. PO Box 370 Somerville, NJ 08876 **Fax: 866-441-4190**

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Minnesota State Insulin Affordability Program

What to Expect Next?

- Fax/Mail completed application. See the bottom of the page for fax number and address.
- Allow at least **2 business days** for processing.
- Enrollment decision will be sent via fax/mail to patient and health care provider. Patients who opted in to autodialed/prerecorded phone calls will also receive enrollment decisions via phone.
- CoverMyMeds Pharmacy will contact your patient to arrange shipment.
- 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 15 for the following year.

If there is a change in address, patient medication or dosage, or if the patient is no longer under your care, please contact Novo Nordisk PAP immediately at 1-866-310-7549 so we can make any adjustments.

Medicare Part D will only receive refills providing medication that will last through the end of their enrollment.

Phone: 866-310-7549 M–F 8am–8pm ET Novo Nordisk, Inc. PO Box 370 Somerville, NJ 08876 **Fax: 866-441-4190**