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

Novo Nordisk Minnesota State Insulin Affordability Program Refill/Change Request Form

Asterisks indicate required field. Do not leave blank.

This form should be used by a health care practitioner to request a refill, to add a new medication, to request a change in medication or change in dosage for a current medication, OR to update the health care practitioner information, such as address, suite number, etc. Form must be submitted directly by the HCP and must include a cover letter/HCP letterhead to clearly identify HCP as the sender.

Applicant Information (One patient per form)

☐ **Check if this request is for a new product or dosage increase**

Patient First Name*:	Last Name*:	Patient DOB*:
Other Medications*:	Known Drug Allergies*:	
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		
Patient ID Number:	Patient's Email:	

Licensed Health Care Practitioner Information

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

Order Information

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®	
Insulin Degludec Injection U-100 (UB)			☐ Vial ☐ FlexTouch®	
Tresiba® (insulin degludec) injection U-200			☐ FlexTouch®	
Insulin Degludec Injection U-200 (UB)			☐ FlexTouch®	
Levemir® (insulin detemir) injection 100 U/mL			☐ Vial ☐ FlexPen®	
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	

By signing below, I acknowledge that I have read and agree to the Health Care Practitioner Declaration on page 2. Products are dispensed as written. (Handwritten/valid electronic signatures accepted; no photocopies, power or attorney, or stamped signatures allowed)

Practitioner's Signature*: Date*:

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

PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.

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Patient Information

Patient First Name*:	Last Name*:	Patient DOB*:

Order Information (continued)

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. **All reorder requests must be made directly by the prescriber to the Novo Nordisk Minnesota State Insulin Affordability Program.** FlexPen®/FlexTouch® are used with Novo Nordisk disposable needles. **Needles will not be sent as part of the order if they are not requested.**

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."

PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.