QuickCheck™ | Rare Blood Disorders

Check your patient's insurance coverage in 4 business hours or less

novo nordisk® | NovoCare® Savings | Coverage | Support

Phone: 1-844-668-6732
Fax: 1-866-488-6576

Monday - Friday
8:00 AM to 8:00 PM ET

* Indicates a required field

THIS FORM IS NOT A PRESCRIPTION

PATIENT/INSURANCE INFORMATION

Patient name:*			
DOB (MM/DD/YYYY):*	Gender†:* ☐ Male ☐ Female		
Home address (No P.O. box):	City:	State:	Zip:*
Primary pharmacy insurance: (Please attach a copy of the insurance card if available)			Phone:
Insurance subscriber name:			DOB (MM/DD/YYYY):
Rx # ID:	Rx Group #:	Rx PCN #:	Rx BIN #:
Primary medical insurance: (Please attach a copy of the insurance card, including front & back, if available)			Phone:
Subscriber name:	Subscriber ID:	Policy/group #:	
Secondary medical insurance:			Phone:
Subscriber name:	Subscriber ID:	Policy/group #:	
Employer name:	Employer group #:		

† 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

What is the primary diagnosis for which you are prescribing a Novo Nordisk factor product? *(required)* *

- ☐ D66 -Congenital Hemophilia A (Factor VIII deficiency) without inhibitors
- ☐ D66 - Congenital Hemophilia A (Factor VIII deficiency) with inhibitors
- ☐ D67 - Congenital Hemophilia B (Factor IX deficiency) without inhibitors
- ☐ D67 - Congenital Hemophilia B (Factor IX deficiency) with inhibitors
- ☐ D68.2 - Other congenital factor deficiency (FVII)
- ☐ D68.2 - Other congenital factor deficiency (FXIII)
- ☐ D68.311 - Acquired hemophilia
- ☐ D69.1 - Qualitative platelet defect (Glanzmann's Thrombasthenia)

Other diagnosis:

ICD-10 code and description: _____

PRODUCT

Select Product(s):

☐ NovoSeven® RT
☐ 1 mg ☐ 2 mg ☐ 5 mg ☐ 8 mg

☐ Novoeight®
☐ 250 IU ☐ 500 IU ☐ 1000 IU ☐ 1500 IU ☐ 2000 IU ☐ 3000 IU

☐ Tretten®
☐ 2500 IU

☐ Rebinyn®
☐ 500 IU ☐ 1000 IU ☐ 2000 IU ☐ 3000 IU

☐ Esperoct®
☐ 500 IU ☐ 1000 IU ☐ 1500 IU ☐ 2000 IU ☐ 3000 IU

☐ Alhemo®
☐ 60 mg/1.5 mL (NDC 0169-2084-15) ☐ 150 mg/1.5 mL (NDC 0169-2080-15) ☐ 300 mg/3 mL (NDC 0169-2081-03)

HEALTH CARE PROFESSIONAL AUTHORIZATION

Prescriber name:*			Preferred method of contact: ☐ Phone ☐ Fax ☐ Email	
Practice name and office contact:			Tax ID #:	
NPI #:*	Phone:*	Fax:*	Email:*	
Address:*		City:*	State:*	Zip:*

Health Care Professional release:* By signing below, I hereby certify that: (a) I am a licensed practitioner, or authorized by a licensed practitioner, in good standing under applicable state law; (b) this insurance coverage check is for one of the above mentioned products which, if prescribed, would be to treat a diagnosis(es) consistent with indications and dosing prescribed in the product's prescribing information; (c) the information I have provided on this QuickCheck form, 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 insurance coverage information. 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 with any questions related to NovoCare®.

Health Care Professional signature (no signature stamps):*	Date:*