rivfloza™ (nedosiran) injection 80mg, 128mg, 160mg

Patient Authorization Form

Phone: 1-844-906-5099
Fax: 1-866-488-6576

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

novo nordisk® | NovoCare® Savings | Coverage | Support

* Indicates a required field

PATIENT INFORMATION

Patient first name:*	**Patient last name:***	
DOB:*	**Patient phone:**	**Patient zip code:**
Primary caregiver first name:	**Primary caregiver last name:**	
Primary caregiver phone:	**Relationship to patient:**	

NOVOCARE® PROGRAM AND HIPAA AUTHORIZATION

By signing below, I give permission for my health care providers, including the pharmacies I use, and my health insurance plans, to disclose information related to me and my treatments for Primary Hyperoxaluria, including but not limited to prescription coverage, medical prescriptions, and health records (collectively, my "Personal Information") to Novo Nordisk and its service providers involved with Novo Nordisk's NovoCare® patient support program (collectively, the "NovoCare Team"), so that I may receive assistance from the NovoCare program ("NovoCare").

I also give permission for the NovoCare Team to use my Personal Information for all of the following purposes: (i) contacting me regarding NovoCare; This Personal Information aids in administering the program "NovoCare®" by: (i) processing this Application; (ii) verifying my information; (iii) identifying and/or determining eligibility under NovoCare® 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 NovoCare®; and (vii) conducting quality assurance and/or other internal business activities in connection with NovoCare®.

I further give permission to the NovoCare® Team to disclose my Personal Information to my health care providers, health insurer(s), caregivers, and Novo Nordisk, for the purposes described above.

I understand and acknowledge that while the NovoCare® Team intends to use and disclose my Personal Information only as described above, once my Personal Information is disclosed pursuant to this authorization, it may no longer be protected by certain federal privacy and security laws and could be re-disclosed to others.

I understand that I do not need to sign this authorization in order to receive treatment, including with Novo Nordisk products, or to receive insurance coverage for my treatment. I also understand that I may revoke (withdraw) this authorization at any time in the future by writing to NovoCare® 501 W. Church St. #405, Orlando, FL 32805. I understand that if I do revoke this authorization, that will not invalidate uses or disclosures of my Personal information made before NovoCare receives my notice of revocation, and that I will no longer be able to participate in NovoCare or receive the services administered by NovoCare®.

I understand that I will receive a copy of this authorization after it is signed below and that the authorization will remain valid for ten (10) years unless a shorter time period is required by applicable law.

☐ 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.

Patient/Legal Representative Signature:*	**Date:***
Legal representative (age must be over 18):	**Relationship to patient:**

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* Indicates a required field

PATIENT INFORMATION

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DOB:*	Patient phone:	Patient zip code:

NOVOCARE® SMS TEXTING AUTHORIZATION (OPTIONAL)

☐ Yes, I have read and understand the NovoCare® SMS Terms of Use at https://www.novocare.com/eligibility/NovoCare-Text.html and realize that Novo Nordisk or its partners may use my Personal Information to provide me with program status updates, quality monitoring, and as more fully explained in Novo Nordisk's Privacy Notice. I understand any calls or texts may be generated using an automated technology and that message and data rates may apply.

NOVOCARE® MARKETING MESSAGING AUTHORIZATION (OPTIONAL)

☐ I agree that Novo Nordisk, its affiliates, or vendors may use my Personal Information to keep me informed about new products, services, special offers, or other opportunities that may be of interest to me, as they become available. These communications may be sent by email [or by text message using an autodialer] and contain material marketing or advertising Novo Nordisk products, goods, or services. I understand that I do not have to consent to receive communications before purchasing goods or receiving other services from Novo Nordisk. I can stop Novo Nordisk from sending me future communications by clicking the "unsubscribe" link within any email I receive, by calling 1-877-744-2579, or by sending a letter containing my contact information (e.g., name, email address, phone) to Novo Nordisk, 800 Scudders Mill Road, Plainsboro, New Jersey 08536. If the communications are sent by text message, I may stop further communications by responding to any such text with "STOP".

NOVOCARE® INCOME VERIFICATION FAIR CREDIT REPORTING ACT [FCRA] AUTHORIZATION FOR THE PATIENT ASSISTANCE PROGRAM (ONLY NEEDED IF PATIENT IS APPLYING TO PAP)

☐ By checking this box, I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA"), authorizing NovoCare®, Novo Nordisk, and its authorized vendor(s) on an on-going basis as needed for the duration of my participation in programs administered by Novo Nordisk NovoCare®, 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 Novo Nordisk.

I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I attest 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 Novo Nordisk Patient Assistance Program.

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Patient first name:*		Patient last name:*
DOB:*	Patient phone:	Patient zip code:

NOVOCARE® PATIENT ASSISTANCE PROGRAM AUTHORIZATION (ONLY NEEDED IF PATIENT IS APPLYING TO PAP)

I hereby certify that I: (i) am a United States citizen or legal resident; (ii) do not have the ability to pay for the medication(s) requested by my health care provider prescription(s). I authorize NovoCare® to determine if I am eligible for the program. Patient Assistance Program requirements can be found at NovoCare.com or call 844-906-5099.

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 is true and correct and that I will verify any of the information provided to PAP upon request; (ii) will verify my application status and receipt of the indicated medication(s) upon request by PAP; (iii) if approved to participate in PAP, I 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. I give permission for Novo Nordisk (and its authorized partners) to contact me about my PAP application at any time.

Lastly, I 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 understand 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.

If a safety concern is reported, I 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/Legal Representative Signature:*	Date:*
Legal representative (age must be over 18):	Relationship to patient:

NOVOCARE® PATIENT MEDICARE PART D ENROLLEE AUTHORIZATION (ONLY NEEDED IF PATIENT IS APPLYING TO PAP)

I agree that if I am approved for PAP as a Part D Enrollee, that I will provide Novo Nordisk with my Part D plan information, including Plan name, Plan ID, Group Number, and Plan address and other contact information. I will provide this information so that NovoCare® can notify my Medicare Part D Plan what specific medication I have been prescribed and am receiving under Novo Nordisk's free drug program, and can further advise the Plan that I will not seek coverage for these products under the Medicare Part D prescription drug insurance plan and will not apply any Novo Nordisk PAP medication towards my True-Out-Of-Pocket (TrOOP) costs.

Patient/Legal Representative Signature:	Date:
Legal representative (age must be over 18):	Relationship to patient:

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