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

Patient Enrollment 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 ☐ New start ☐ Reauthorization ☐ Restarting treatment ☐ Transitioning from: _____

SERVICES REQUESTED

Access Support Requested:

☐ Prior Authorization/Reauthorization support request
If PA approved, provide PA approval number _____ with dates from: _____ to: _____.

☐ Appeals support request

Additional Services:

☐ JumpStart™[ab] request for patients experiencing a delay in insurance coverage

☐ Rivfloza™ Injection Training: ☐ In-person ☐ Virtual

☐ Starter Kit for new patients starting therapy

☐ NovoCare® Savings Offer (if eligible). For complete terms and conditions, visit RivflozaSavingsEligibility.com.

[a] Terms and conditions of JumpStart™ require active, timely prescriber support of Prior Authorization and/or Appeal documentation submission.

[b] Patients who have been prescribed Rivfloza™ for an FDA-approved indication and who have commercial insurance may be eligible to receive a limited supply of free product from JumpStart™. Patient is not eligible if he/she participates in or seeks reimbursement or submits a claim for reimbursement to any federal or state health care program with prescription drug coverage, such as Medicaid, Medicare, Medigap, VA, DOD, TRICARE, or any similar federal or state health care program. JumpStart™ product is provided at no cost to the patient or the HCP, is not contingent on any product purchase, and the patient and HCP must not: (1) bill any third party for the free product, or (2) resell the free product. No purchase necessary.

PATIENT/INSURANCE INFORMATION

Patient first name:*	**Patient last name:***	**DOB (MM/DD/YYYY):***
Gender†:* ☐ **Male** ☐ **Female**	Preferred language: ☐ English ☐ Spanish ☐ Other:	
Home address (No P.O. box):	City:	State: **Zip:***
Shipping address (If different from Home Address):	City:	State: **Zip:***
Email:	Primary phone:*	Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening
Primary guardian/caregiver (required if patient under 18 years old):*		
DOB (MM/DD/YYYY):	Relationship to patient:	
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 #:
Primary pharmacy insurance: (Please attach a copy of the insurance card, including front & back, if available)		Phone:
Rx # ID:	Rx Group #:	Rx PCN #: Rx BIN #:
Employer name:		

† 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 Rivfloza™ (nedosiran) injection? *(required)* *

☐ E72.53 - Primary Hyperoxaluria

PH Type:* ☐ PH1 ☐ PH2 ☐ PH3 **eGFR:*** ☐ eGFR ≥30 mL/min/1.73 m2 ☐ eGFR < 30 mL/min/1.73 m2

Weight (kg):* _____ Date: ___/___/_____

Other diagnosis:

ICD-10 code and description: _____

PRESCRIPTION

If requesting JumpStart™ please select both Prescription fields *(required)* * ☐ **JumpStart™ Prescription** ☐ **Ongoing Prescription**

Single Use Pre-filled Syringe:

☐ RIVFLOZA™ (nedosiran) 160mg/1 mL Single Use Pre-filled Syringe

☐ RIVFLOZA™ (nedosiran) 128mg/0.8 mL Single Use Pre-filled Syringe

Directions:

Inject pre-filled syringe SC once a month

Quantity_____ Days Supply_____ Refills_____

OR

Vial:

☐ RIVFLOZA™ (nedosiran) 80mg/0.5ml Single use Vial

☐ 1mL syringe with attached 27 gauge, ½" needle (number of syringes should be equivalent to the number of vials needed)

Directions:

Inject_____ mg SC once per month

Quantity _____ Days Supply_____ Refills _____

PRESCRIBER AUTHORIZATION

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

Prescriber Attestation:* By signing below, I hereby certify that: (a) I am a licensed practitioner, in good standing under applicable state law; (b) the product being prescribed is to treat a diagnosis(es) consistent with indications and dosing described in the product's prescribing information; (c) the information I have provided on this enrollment form is, to the best of my knowledge, true, complete, and accurate in all respects; and (d) I have obtained authorization from the patient, or the patient's legal representative, to share the patient's personally identifiable health information with Novo Nordisk, Inc. and its vendors, including AssistRx (collectively, "NovoCare") so they may use the information to assist the patient in connection with this prescription, including by contacting the patient using the information provided above."

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®. Further, I appoint NovoCare®, on my behalf, to convey this prescription to the dispensing pharmacy. 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 the authorization they provided, as referred to above. I give you permission to contact me, or the above named patient/Caregiver, with any questions related to NovoCare®.

Prescriber signature (no signature stamps):* **Date:***