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

Novo Nordisk Patient Assistance Program Application

The Novo Nordisk Diabetes Patient Assistance Program (PAP) provides medication to qualifying applicants at no charge. If the applicant qualifies under the Novo Nordisk Diabetes PAP guidelines, up to a 120-day supply of the requested medication(s) or device(s) will be shipped to the **applicant's licensed practitioner for dispensing.**

Eligibility Requirements

You may qualify if:

- You are a US citizen or legal resident
- Your total household income is at or below **400%** of the federal poverty level (FPL) (NeedyMeds website lists current FPL guidelines)
- You have **no** insurance
- You **participate in Medicare**
- You are **not enrolled** in, **plan to enroll in**, or **are eligible for** any other federal, state or government program, such as Medicaid, Medicare Low Income Subsidy (LIS), or Veterans (VA) Benefits

What to send?

- Completed application (signed and dated by both patient and prescriber)
- Proof of income

IMPORTANT

- Sign and Date **ALL** applicable sections.
- Ensure **ALL** *required fields have been completed.
- Include **ALL** required supporting documentation.
- Mail/Fax completed application & copies of required income documentation.

Any missing/incomplete/illegible information may cause a delay in processing.

Questions?

Phone: **866-310-7549** Monday-Friday 8AM–8PM ET

Fax: 866-441-4190

Patients: NovoPAP.com **HCPs:** NovoPAPHCP.com

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Novo Nordisk Patient Assistance Program Application

Check one: ☐ New Application ☐ Re-Enrollment

*Asterisks indicate required field. Do not leave blank.

PATIENT SECTION

Patient First Name*:	Last Name*:	Patient DOB*:
Patient's Street Address* (NO PO BOX):		
City:	State:	Zip:
Home Phone*:	Mobile Phone*:	
Gender: ☐ Male ☐ Female ☐ Prefer not to disclose	Email:	

Insurance

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

Plan Name: Member ID: Phone#

☐ Employer-supplied or commercial/private drug coverage
☐ Medicare Prescription Drug Coverage
(include a copy of the front and back of your card)
☐ 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)

Not sure if you have Medicare Rx coverage? 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.

Patient Authorized Representative (Optional)

You may provide the name of an individual (i.e., spouse, sibling, child, etc.) whom you authorize 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

Fair Credit Reporting Act (FCRA) Consent

You have the option to allow PAP to perform an electronic income verification to process your application.
☐ Please check here if you wish to choose this option and not send in your income documents as noted on the Instructions Page.

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.

If you do not consent to an electronic income verification, please complete the information below and provide proof of income.

Total Household Annual Income $

# of people living in your household* (include yourself, spouse/partner, all adults)	# of dependents (under 18 years of age)*

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, that 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.

Signature required ONLY if patient is a Medicare Part D enrollee Member Number/ID#*:

Patient or Parent/Guardian/Legal Representative Signature:

SIGNATURE REQUIRED

PAP Application Enrollment Year: Date:

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Novo Nordisk Patient Assistance Program Application

*Asterisks indicate required field. Do not leave blank.

PATIENT SECTION (continued)

Patient Information

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

HIPAA Authorization

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), caregivers, 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 healthcare providers, pharmacies, service providers, insurer(s), etc. **However, if I (or my parent/guardian/legal representative) 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 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.

☐ 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 or Legal Representative Signature*: Date*:

SIGNATURE REQUIRED

Legal Representative: Relationship to patient: Phone:

Telephone Consumer Protection Act ("TCPA") Communication Consent

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, 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 this consent is not required, or a condition of purchase and it can be revoked 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.

By providing a phone number and signing below, I acknowledge that I have read and agree to the TCPA Communication Consent above.

Phone*:

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.

Program Authorization & Certification

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.

☐ 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 or Legal Representative Signature*: Date*:

SIGNATURE REQUIRED

Legal Representative: Relationship to patient: Phone:

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Novo Nordisk Patient Assistance Program Application

*Asterisks indicate required field. Do not leave blank.

PRESCRIBER SECTION

Patient First Name*:	Last Name*:	Patient DOB*:
Known Drug Allergies*:		

Prescriber Information (All medication will be shipped to the prescriber. No PO Box permitted.)

First Name*:	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:	

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

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 Diabetes 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. 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."

Practitioner's Signature*: Date*:

SIGNATURE REQUIRED

Rx

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®	
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 6mm (100 needles/box)				
Zegalogue® (dasiglucagon) injection 0.6 mg/0.6 mL			☐ Auto-injector 1-pack ☐ Auto-injector 2-pack ☐ Prefilled Syringe 1-pack ☐ Prefilled Syringe 2-pack	
NovoPen Echo®			☐ 1 pen	

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.
FlexPen®/FlexTouch® come in 5 pen packages and are used with Novo Nordisk disposable needles. **Needles will not be sent as part of the Program order if they are not requested.**

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

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PRESCRIBER SECTION (continued)

Patient Information

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

Rx (continued)

Product	Max Dose/ Day (units)	Sig/Directions (e.g., QD, BID)	Formulation	Quantity
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 0.25 mg or 0.5 mg			☐ 1 pen pack	
Note: Ozempic® .25 mg dosage is intended for treatment initiation and is not effective for glycemic control. Prescribing information can be found at www.novo-pi.com/ozempic.pdf				
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 1 mg			☐ 1 pen pack	
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 2 mg (1 pen pack)			☐ 1 pen pack	
Victoza® (liraglutide) injection 1.2 mg (2 pen pack)			☐ 2 pen pack	
Victoza® (liraglutide) injection 1.8 mg (3 pen pack)			☐ 3 pen pack	
Xultophy® 100/3.6 (insulin degludec & liraglutide injection) 100 U/mL & 3.6 mg/mL			☐ 5 pen pack	
Rybelsus® (semaglutide) tablets *Select **1** of the combination options*			☐ 3 mg / 7 mg ☐ 7 mg / 7 mg ☐ 7 mg / 14 mg ☐ 14 mg / 14 mg	60-day supply
			☐ 7 mg ☐ 14 mg	120-day supply
Note: Rybelsus® 3mg dosage is intended for treatment initiation and is not effective for glycemic control. Prescribing information can be found at www.novo-pi.com/rybelsus.pdf				
All orders will be filled with a **120-day** supply unless otherwise indicated by the prescriber. Prescribers, please complete the application with max daily dose and sig accordingly. 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.**				

What to Expect Next?

- Mail/Fax completed application & required income documentation.
- Allow 2 business days for processing.
- Enrollment decision will be sent via mail/fax to patients and healthcare providers. Patients who opted in to autodialed/prerecorded phone calls will also receive enrollment decisions via phone.

- Once approved, allow an additional 10-14 business days for delivery to HCP office.
- 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 15th for the following year.

Prescribers - Auto-Refill

(Currently not available for residents in ME/MN)

All new applicants will be automatically enrolled into our auto-refill program for all eligible medications[a].

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 or cancel any future auto-refills. Any medication provided under PAP to qualified patients under your care must be delivered to , and accepted by, you/your office staff for further dispensing, only to that specific patient who qualified for PAP. Auto-refill will end when patient's enrollment period has expired.

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

Prescribers, check this box to opt-out of auto-refills ☐

(Note: If opting out of auto-refill, prescribers are responsible for initiating any future refills.)

[a]NovoPen Echo®, Zegalogue®, and ALL 60-day supply combinations of Rybelsus® are **NOT** eligible for auto-refill.