



Patient Information (to be completed by patient)

Patient Name: _____ Date of Birth: ___/___/___
 Patient Address: _____

 Patient Phone Number: _____ Social Security Number: _____
 (required)

Eligibility Requirements (to be completed by patient)

A. Annual household adjusted gross income from most recent federal tax return \$ _____
 (Attach a copy of the patient's most recent Federal Tax Return [1040], Social Security Income [SSA 1099], Pensions, Interest, Retirement, Child Support, etc. This information is only required annually. It is not required for reorders.)
 B. Number of dependents in household (including self) _____
 C. Do you qualify for private, local, state, or federal prescription coverage/reimbursement? Yes No

**Please Attach Proof of Income Documents for all New Applications and Annual Renewals
Incomplete Applications Will be Returned**

Health Care Practitioner Information (to be completed by Health Care Practitioner)

Practitioner Name: _____ State License #: _____ Exp Date: ___/___/___
 Shipping Address: _____
 (no PO box number)
 Phone Number: _____ Fax Number: _____

Activella® (estradiol/norethindrone acetate) tablets (prescription required; to be completed by Health Care Practitioner)

Please check box	List #	Description
<input type="checkbox"/>	0169-5175-11	Activella® 0.5 mg/0.1 mg Only available in a 5-pack of 1X28 tablets for this program (Rx must indicate this)

Vagifem® estradiol vaginal tablets (prescription required; to be completed by Health Care Practitioner)

<input type="checkbox"/> Quantity for Initial 5 Months	<input type="checkbox"/> Quantity for Renewal	List #	Description
4	5	0169-5173-03	Vagifem® 8
1	0	0169-5173-04	Vagifem® 18

My signature certifies that goods received from Novo Nordisk are for the use of the above-named patient only. These goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. I will not bill or seek payment from the patient or any third party payor, including, but not limited to, Medicaid or private insurance plans. Novo Nordisk reserves the right to recall the product when necessary.

Health Care Practitioner Signature: _____ Date: _____
 (No photocopies or stamp signature)

I reviewed the above Patient Assistance Program ("the program") application completed by my physician and the information included on this form is accurate and correct. I certify that payment for the requested medication represents a financial hardship to me, and that I do not have access to third party reimbursement for the medication. I authorize my physician to disclose the information on this form to Novo Nordisk for purposes of administering the program. I understand that once my physician discloses this information to Novo Nordisk, the information will no longer be protected by federal privacy protection laws, but that Novo Nordisk will not further disclose the information included on this form to anyone else, other than agents or vendors that may be employed by Novo Nordisk to assist Novo Nordisk in administering the program or in sending me support literature and special offers. I understand that I have the right to receive a copy of this authorization from my physician. My physician will not make any further disclosures of the information on this form to Novo Nordisk after one year from the date of execution of this form. I understand that I can revoke this authorization at any time by writing to my physician and asking him or her not to further disclose my information. I understand that my physician will treat me even if I do not sign this form, but that I will not be able to participate in the program.

Patient Signature: _____ Date: _____
 (No photocopies or power of attorney signature)

Please call Novo Nordisk at 1-866-310-7549 if you have questions.
 Return this form by fax to 1-866-441-4190 or mail to Novo Nordisk Patient Assistance Program, Hormone Therapy, PO Box 181640, Louisville, KY, 40261.
 Novo Nordisk Inc. reserves the right to modify or cancel this program at any time without notice. All requests are subject to product availability and patient eligibility verification.