Patient Assistance Program
Novo Nordisk Inc.
PO Box 18648
Louisville, KY 40261
1-888-868-9852

☐ **New Application**
☐ **Refills** (complete page 2 only)

Fax: 1-888-868-9853

Instructions:

- Health Care Practitioner Information Section must be filled out completely
- Patient Information and Eligibility Section must be filled out completely
- **Attach the completed product request form for a 90-day supply of medication for all products except where indicated differently (see official program application)**
- **Attach a signed prescription(s) for the Novo Nordisk product (Please note, the application cannot be finalized without receipt of product request form and prescription.)**
- **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 90-day reorders**
- **Submit the completed application with photocopies of the required proof of income to FAX 1-888-868-9853.**
- **Faxed requests must be sent from the health care practitioner's office.** Please allow up to 10 business days for processing. Applications may also be mailed to the address above. Allow an additional 7 days for processing if mailed
- Both the patient and health care practitioner will be advised in writing of approved and denied requests
- All incomplete applications will be sent to either the patient or health care practitioner for completion

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Program Eligibility:

- Patient must be a US Citizen with a valid Social Security Number
- Patient cannot have or qualify for any government prescription coverage such as Medicare, Medicaid, Veterans Administration, or any state or local programs
- Patient cannot have or qualify for any private prescription coverage such as an HMO or PPO
- Patient's total household income must be at or below 200% of the Federal Poverty Level

Approved patients will receive a 90-day supply of medication. Patient will be enrolled in the program for a rolling 12-month period. A new application must be submitted for each new product request. Income documentation is only required annually.
All requests are subject to product availability and patient eligibility verification.
Novo Nordisk reserves the right to modify or cancel this program at any time without notice.

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If you do not want to be included in future mailings or communications from Novo Nordisk please call 1-888-868-9852 or send a brief note with your name and address to Novo Nordisk at 800 Scudders Mill Road, Plainsboro, New Jersey 08536.

Please call Novo Nordisk at **1-888-868-9852** if you have questions.

Return this form by fax to **1-888-868-9853** 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.

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Patient Information (to be completed by patient)

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

Patient Address:_____
(no PO box number)
_____

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 90-day reorders.)

B. Number of dependants 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 Incomplete Applications Will Be Returned

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

Practitioner Name:_____

State License #: _____ Exp. Date:_____/_____/_____ NPI Number: _____

Shipping Address: _____
(no PO box number)
_____

Phone Number: _____ Fax Number: _____

Prescription Required (to be completed by Health Care Practitioner)

Therapy Cycle	Refills	Product Selection	Directions
☐ Initial Therapy (New Starts)	Zero refills	☐ Vagifem® 10mcg tab, 18ct box 0169-5176-04	☐ Insert 1 tablet vaginally once daily for 2 weeks, then twice weekly thereafter; Dispense 1-month supply
☐ Continued Therapy (Renewals)	Refills: _____	☐ Vagifem® 10mcg tab, 8ct box 0169-5176-03	☐ Insert 1 tablet vaginally twice weekly; Dispense 3-month supply

My signature certifies that I am a licensed health care practitioner eligible under state law to prescribe the requested medication(s) listed on the attached order, shipped from Novo Nordisk direct to my patient, and that I am not prohibited from participating in federally funded health care programs. I further certify that all information provided in the Health Care Practitioner Information section is correct. I agree that medication(s) provided to the applicant named in the Patient Information section will be provided to such eligible applicant for his or her own use without charge. I consent that Novo Nordisk may contact the applicant named in the Patient Information section for verification of applicant status and receipt of the indicated medication(s). I further consent that Novo Nordisk may perform an on-site audit of Novo Nordisk Hormone Therapy 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 provided by the Novo Nordisk Hormone Therapy PAP from any government program or third-party insurer and will not apply any Novo Nordisk Hormone Therapy PAP medication towards the applicant's True-Out-Of-Pocket (TrOOP) costs. I also understand that eligibility under the PAP is subject to Novo Nordisk's discretion and that Novo Nordisk reserves the right to modify or terminate the PAP at any time. Finally, I certify that I receive no direct or indirect payments related to the PAP.

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

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For Patient

Patient Declaration

I certify:

- I do not have the ability to pay for the medication(s) requested by my health care practitioner on the attached prescription(s)
- All information provided in this application is true and correct and that I will verify any of the information I provide to the Patient Assistance Program (PAP) upon request by the PAP
- To verify my PAP application status and receipt of the indicated medication(s) upon request by the PAP
- If approved to participate in the PAP, I will not seek reimbursement for the medication(s) requested from any government program or third-party insurer

I understand and agree:

- That my eligibility to participate in the PAP is subject to Novo Nordisk's decision and that Novo Nordisk may modify or terminate the PAP at any time
- That I may be required to provide proof of ineligibility for certain other prescription drug coverage programs in order to meet the eligibility requirements for the PAP
- That I am required to report any changes to my health insurance and prescription drug coverage to the PAP

Patient or Patient Representative's Signature: _____ **Date:** _____
(No photocopies or power of attorney signature)

If signed by Patient Representative, describe relationship to patient and authority to make medical decisions for patient:

_____

Novo Nordisk Patient Authorizing to Use and Disclose Health Information

Patient Authorization to Share Health Information. I give permission to my health care practitioners, my health plan, and insurers to give health and other information about my use or need for medications provided under the PAP to third-party Novo Nordisk vendors in charge of administering the PAP. My health and other information are referred to below as "Information."

I give permission to Novo Nordisk and its third-party vendors to further use and disclose my Information in connection with the PAP. I understand:

- That people with the PAP, Novo Nordisk, or others working on behalf of the PAP or Novo Nordisk may see and use my Information for administering the PAP
- That safety information received during the program concerning a Novo Nordisk product will be forwarded to Novo Nordisk, where the information is collected in the interest of patient safety. The information will be filed in a global database and the information may be reported to regulatory authorities. Novo Nordisk will retain the data as long as required by applicable rules and regulations
- That my Information will include my name, address, social security number, income, prescription coverage, prescription for medication(s), financial documents and insurance records
- That my Information will be used to see if I meet the requirements to participate in the PAP, to ship appropriate medication(s)
- That I will be notified by the PAP if I do not meet the requirements to participate in the PAP

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Without limiting the purposes for the disclosure of Information set forth above, I understand:

- That the PAP, Novo Nordisk, and others helping them will keep my Information private, but that the federal privacy laws may no longer protect my Information once it is disclosed, and that my information may be legally re-disclosed by recipients if not prohibited by state law
- That unless required by law to expire at an earlier date, this authorization will extend for as long as I participate in the PAP and will thereafter expire
- That I may cancel this authorization at any time by giving written notice to Novo Nordisk at the address on this form, but my cancellation will not change any actions taken with my Information before cancelling
- That I have the right to receive a copy of this authorization from my health care practitioner and/or Novo Nordisk, and that I may inspect/obtain a copy of the information disclosed pursuant to this authorization
- That I can refuse to sign this form, and that if I refuse to sign this form, it will not change the way that my health care practitioners, health plans, and insurers treat me
- That if I do not sign this form, I will not be able to participate in the PAP

Patient or Patient Representative's Signature: _____ **Date:** _____
(No photocopies or power of attorney signature)

If signed by Patient Representative, describe relationship to patient and authority to make medical decisions for patient:

_____

Phone: _____ **Mobile Phone:** _____

I agree that the information I am providing may be used by Novo Nordisk, its affiliates, or vendors 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 CONTAIN MATERIAL MARKETING OR ADVERTISING NOVO NORDISK PRODUCTS, GOODS, OR SERVICES.*** Novo Nordisk will take appropriate measures to protect my information. I can stop Novo Nordisk from sending me future communications by calling 1-888-868-9852, sending a brief note with my name and address to Novo Nordisk at 800 Scudders Mill Road, Plainsboro, New Jersey 08536, or by clicking on the "unsubscribe" link which will be available in future email communications. By providing my information to Novo Nordisk and acknowledging below, I certify that I am at least eighteen (18) years of age.

Patient or Patient Representative's Signature: _____ **Date:** _____
(No photocopies or power of attorney signature)

If signed by Patient Representative, describe relationship to patient and authority to make medical decisions for patient:

_____

Email (optional): _____

☐ Please check the box if you are interested in receiving phone calls regarding refill reminders and your enrollment status in the Hormone Therapy PAP. By checking the box, I agree to be contacted by Novo Nordisk at the phone number I have provided, and that Novo Nordisk may use auto-dialers and/or prerecorded messages to contact me. I understand that I am not required to consent to this agreement as a condition of any purchase of goods or services.