patient assistance program

Novo Nordisk Patient Assistance Program Application

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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, a 120-day supply of the requested medication(s) or device(s) will be shipped to **the applicant's licensed practitioner for dispensing.**

The Novo Nordisk PAP is free.

There is no registration charge or monthly fee for participating in the Novo Nordisk PAP.

Patient eligibility

- **Patient must be a US citizen or legal resident**
- **Patient cannot have or qualify for:**
  - Any private prescription coverage, such as an HMO or PPO
  - Department of Veterans Affairs (VA) prescription benefits
  - Any federal, state, or local program such as Medicare or Medicaid. **Exceptions include:**
    - Medicare Part D patients who have spent $1,000 on prescription medicine in the current calendar year
    - Patients who **have applied for and been denied** Medicare Extra Help/Low Income Subsidy (LIS) and are Medicare eligible but do not have Medicare Part D coverage. To apply for LIS, please contact the Social Security Administration (SSA) at 800-772-1213 (TTY 800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/
    - Patients who are Medicaid eligible must **have applied for and been denied** Medicaid to be eligible for the Novo Nordisk PAP
- **Patient's total household income must be at or below 300% of the federal poverty level (FPL)**
  - For further information on FPL in your state, please visit the Families USA website at http://familiesusa.org/product/federal-poverty-guidelines

For a full list of products covered, please visit:

Our company website at **NovoNordisk-US.com** (Patients/Patient Assistance Program section), our health care professional website at **NovoMedLink.com,** or our patient website at **Cornerstones4Care.com**

NOTE: New patients approved for the Novo Nordisk PAP are eligible for insulin vials only.

See next page for instructions.

PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.

Instructions for Completing the Application

Complete ALL fields to avoid return of incomplete application

- ☐ Make sure the application is signed by the prescriber AND dated
- ☐ Remember to include disposable pen needles in the order information if applicable
- ☐ Make sure the patient signs the certification section AND, if a Medicare Part D enrollee, the patient must also sign the Medicare Part D certification. **Medicare Part D enrollees must have spent $1,000 on prescription medicine in the current calendar year before submitting this application**
- ☐ Include all documents required per the **"Documents needed"** section below
- ☐ Fax the completed application and proof of income to 866-441-4190, or mail them to Novo Nordisk Inc., PO Box 370, Somerville, NJ 08876

Documents needed

- Proof of income required. Please provide one of the following items to show your adjusted gross annual household income:
  - ☐ Copy of the 2 most current pay check stubs or earning statements for all working members of your household
  - ☐ Copy of last year's Federal Income Tax Return (1040)
  - ☐ Copy of Social Security income, pension, and other income statements, including interest or dividend statements
  - ☐ Copy of W-2 or 1099 Form
  - ☐ Copy of Unemployment Benefit statement
- Medicaid denial (if appropriate)
- Medicare Part D out-of-pocket expenditures (if appropriate)
  - ☐ Photocopy documentation showing that the patient has spent $1,000 on prescription medicine for the relevant benefit year (letter from plan provider, statement, explanation of benefits (EOB), or clearly dated pharmacy printout showing amount paid for each medicine)

NOTE: New and annual renewal applications without proof of income documentation are considered incomplete.

What to expect next

Allow 7 to 10 business days for processing. A representative will reach out via mail with more information regarding the application status.

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Part 1 of 3: Provider Information

FOR HEALTH CARE PRACTITIONER		
A	Patient's Name:	Date of Birth: ___/___/_____ MM DD YYYY

B	**Licensed Health Care Practitioner Information**	
	Practitioner's Name:	State License Number: Expiration Date: NPI Number:
	Practitioner's Shipping Street Address (no PO Box number):	
	Practitioner's Shipping City, State, & ZIP:	
	Office Phone: ___-___-____	Office Fax: ___-___-____
	Office E-mail:	Office Contact Name:
	Weekdays/Times That Deliveries Not Accepted:	

C	**Order Information (include disposable pen needle order if applicable)**		
	Product Name	**Max Dose Per Day (in units)**	**Sig**

NOTE: New patients approved for the Novo Nordisk PAP are eligible for insulin vials only.
All orders will be filled with a 120-day supply. A reorder request must be made to receive an additional order.

D	**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. 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 perform an on-site audit of 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 the Novo Nordisk Diabetes PAP from any government program or third-party insurer and will not apply any Novo Nordisk Diabetes 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.	
	Practitioner's Signature (no photocopies or power of attorney signature): PRACTITIONER SIGNATURE	**Date:**

PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.

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PO Box 370
Somerville, NJ 08876
Phone: 866-310-7549
Fax: 866-441-4190

☐ New Application
☐ Annual Renewal

Part 2 of 3: Patient Information

FOR PATIENT

A

Patient's Name:	Date of Birth: ___/___/_____ (MM/DD/YYYY)
Gender: ☐ Male ☐ Female	Social Security Number: ___-___-_____
Patient's Street Address:	
Patient's City, State, & ZIP:	

As part of this PAP, Novo Nordisk will provide you with refill reminders and notifications regarding program enrollment via phone calls. By checking the checkbox below, I hereby consent to receive:

☐ Autodialed and prerecorded calls to the phone number(s) provided below. I understand and agree that by checking this box and entering my phone number(s), I am granting my express written consent to receive autodialed and prerecorded phone calls from Novo Nordisk and its PAP service providers on my mobile phone and/or landline. I also understand that my consent is optional and can be freely withdrawn.

Phone: ___-___-_____	Mobile Phone: ___-___-_____
E-mail:	

Patient-Authorized Representative Information

Name: Relationship to Patient:

Phone Number: ___-___-_____

B

Annual household adjusted gross income from most recent federal tax return: $_____

Number of people in household (including patient): _____	Number of people in household under 18: _____

C

Does the patient have private prescription insurance coverage? ☐ Yes ☐ No

Is the patient enrolled in Medicaid? ☐ Yes ☐ No

Is the patient enrolled in Medicare Part A and/or Part B? ☐ Yes ☐ No	Medicare ID Number:

Is the patient enrolled in a Medicare Part D Plan? ☐ **Yes** ☐ **No**
(If the answer is Yes, proof of out-of-pocket spending of $1,000 must be submitted with this application.)

Medicare Part D ID Number:

Is the patient enrolled in a Department of Veterans Affairs (VA) plan? ☐ Yes ☐ No

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Part 3 of 3: Patient Certification and Authorization

FOR PATIENT

A

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's or Patient Representative's Signature (no photocopies or power of attorney signature): PATIENT SIGNATURE	**Date:**

B

Required for MEDICARE PART D ENROLLEE. I understand and agree:

- That if I am approved for the Patient Assistance Program (PAP), I will receive a 120-day supply of the medication(s) and/or device(s) from the PAP
- That I am eligible to receive medication from the PAP through the end of this calendar year
- That I will not seek the requested Novo Nordisk medication(s) from my Medicare Part D prescription plan while receiving the medication(s) from the PAP and that I am not eligible for reimbursement for any medication dispensed by the PAP from any government program or third-party insurer and will not apply any PAP medication(s) toward my True-Out-of-Pocket (TrOOP) costs

Signature is required only if patient is a Medicare Part D enrollee. **Patient's or Patient Representative's Signature (no photocopies or power of attorney signature):** PATIENT SIGNATURE	**Date:**

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 Novo Nordisk or the PAP may give my Information to the Centers for Medicare & Medicaid Services (CMS) to confirm my Medicare Part D enrollment status and let CMS and my Medicare Part D plan know of my enrollment in the PAP.
- 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.

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 this authorization will expire 1 year from the date this form is signed.
- That I may cancel this authorization at any time by giving written notice to Novo Nordisk at the address on this form, but my cancelation will not change any actions taken with my Information before canceling.
- 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's or Patient Representative's Signature (no photocopies or power of attorney signature):	**Date:**
PATIENT SIGNATURE	

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