PATIENT TRIAL PROGRAM

Patients who have been prescribed a Novo Nordisk hemophilia and rare bleeding disorder product for an FDA-approved indication, and who have commercial insurance, may be eligible to receive a limited supply of free product. 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. Product is provided at no cost to the patient and is not contingent on any product purchase. Physician and patient shall not: (1) bill any third-party for the free product, or (2) resell the free product.

PATIENT ELIGIBILITY

- ❑ **Patient has commercial prescription coverage, such as an HMO or PPO**
- ❑ **Patient has been newly prescribed a Novo Nordisk factor product for an indicated condition**
- ❑ **Patient is Novo Nordisk factor product-naïve**

PATIENT/INSURANCE INFORMATION

Patient name: _____ DOB: _____ Preferred language: ❑ English ❑ Spanish

❑ Male ❑ Female Primary phone: _____ Alternate phone: _____

Alternate contact name: _____ Relationship to patient: _____

Address: _____ City: _____ State/Zip: _____

Email: _____

Primary insurance: _____ **Pharmacy benefit insurance:** _____

Phone: _____ Phone: _____

Subscriber name: _____ Member ID: _____

Subscriber ID #: _____ Group ID #: _____

Policy/group #: _____ **Secondary insurance:** _____

Subscriber ID #: _____

Employer name: _____ **Employer group #:** _____

DIAGNOSIS

What is the primary diagnosis?

- ❑ 286.0 (D66) Congenital hemophilia A (Factor VIII without inhibitors)
- ❑ 286.0 (D66) Congenital hemophilia A or B (with inhibitors)
- ❑ 286.1 (D67) Congenital hemophilia B (Factor IX without inhibitors)
- ❑ 286.2 (D68.2) Other congenital factor deficiency (FXIII)
- ❑ 286.3 (D68.2) Other congenital factor deficiency (FVII)
- ❑ 286.52 (D68.311) Acquired hemophilia
- ❑ 287.1 (D69.1) Qualitative platelet defect (Glanzmann's Thrombasthenia)

PRESCRIPTION

Order Information (Include prescription for 23G [adult] or 25G [pediatric] infusion supplies if applicable. Please submit an actual prescription with the strengths and assay limits.) Quantity limits apply.

Product name	**Dose**	**Infusion instructions**	**Quantity to dispense**

MEDICAL ASSESSMENT

Patient height: _____ **Patient weight:** _____ (kg)

Allergies: _____ **IV access:** ❑ PIV/butterfly ❑ Implanted port ❑ PICC ❑ Central line

Additional information: _____ **Has the patient used a Novo Nordisk product to treat any diagnosis in the section above?** ❑ Yes ❑ No

PHYSICIAN AUTHORIZATION

Physician name: _____ License #: _____

Practice name/office contact: _____ DEA #: _____ Tax ID #: _____

Phone: _____ Fax: _____

Address: _____ City: _____ State/Zip: _____

Health Care Provider Declaration: My signature certifies that I am a licensed health care provider eligible under state law to prescribe the requested medication(s) listed on the attached order 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 Provider Information section is correct. I agree that medication(s) provided to me by Novo Nordisk for the applicant named in the Patient 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 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 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 the NovoSecure™ program 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 NovoSecure™ program from any government program or third-party insurer. I also understand that eligibility is subject to the discretion of Novo Nordisk and that Novo Nordisk reserves the right to modify or terminate the program at any time. Finally, I certify that I receive no direct or indirect payments related to the program.

_____	_____	_____
Physician signature (no signature stamps)	**NPI #**	**Date**

Note: The patient's legal guardian MUST sign and date the Patient Authorization on the next page.

PATIENT AUTHORIZATION

Patient authorization and signature

I, the patient, understand that RxCrossroads, LLC, acting on behalf of Novo Nordisk Inc. (collectively, NovoSecure™), must use, share, and store my protected health information (PHI) in order to provide NovoSecure™ support. I hereby authorize NovoSecure™ to contact my health care provider, pharmacy, insurance company, or other third-party payers, and for such parties to give NovoSecure™ all necessary medical records and payer information, including my medical history, clinical notes, test results, prescription drug information, and insurance information. I understand that a copy of this authorization will be provided to anyone disclosing information to NovoSecure™ so that it may be kept with my records. This authorization expires once I have notified NovoSecure™ that I have completed my Novo Nordisk treatment (unless a shorter time period is required by state law), or unless I notify both my health care provider and NovoSecure™ (at fax number 1-888-508-8200) in writing that I withdraw my approval to share my health information. My withdrawal of approval will not affect any disclosure of PHI made prior to my withdrawal.

I understand that once my health information is released to NovoSecure™, it may no longer be protected by state and federal law but that NovoSecure™ will protect such information and use it only for the purposes stated above. I understand that NovoSecure™ may share my PHI with other parties in order to administer the program. I understand that I have a right to receive a copy of this authorization.

I understand that I do not have to sign the authorization form. If I choose not to sign it, my ability to obtain treatment and my eligibility for benefits under my health plan will not be affected. However, if I do not sign the authorization form, NovoSecure™ may not be able to provide reimbursement help or find out if I am eligible for any other NovoSecure™ support.

Print patient's name		Print legal representative's name	
Signature of patient	OR	Signature of legal representative (parent or guardian)	Date

If you would like to enroll in NovoSecure™ please sign below

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 **1-877-744-2579**, sending a brief note with my name and address to Novo Nordisk at 800 Scudders Mill Road, Plainsboro, NJ 08536, or by clicking on the "unsubscribe" link 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.

Print patient's name		Print legal representative's name	
Signature of patient	OR	Signature of legal representative (parent or guardian)	Date