Novo Nordisk
Patient Assistance Program Application

patient assistance program

novo nordisk®

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

☐ New Application
☐ Annual Renewal

Part 2 of 3: Patient Information

Be sure to read all instructions before completing forms. Please type or print legibly.

FOR PATIENT

A

Patient's Name: Henry Walter

Date of Birth: 11 (MM) / 09 (DD) / 1944 (YYYY)

Gender: ■ Male ☐ Female

Social Security Number: 430-84-6979

Patient's Street Address: 96 N Summit Ridge Dr

Patient's City, State, & ZIP: Williford, AR 72482

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 I also understand that my consent is optional and can be freely withdrawn.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: 870-540-9923

Mobile Phone: ___-___-____

E-mail: hkw66@yahoo.com

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): 2

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 coverage gap must be submitted with this application.)

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

Practitioner's signature is required on Part 1.
Patient's or patient representative's signatures are required on Part 3.
Fax all forms and other required information to: 866-441-4190

Novo Nordisk
Patient Assistance Program Application

patient assistance program

novo nordisk®

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:**

Novo Nordisk Patient Authorization to Use and Disclose Health Information

patient assistance program

novo nordisk®

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): PATIENT SIGNATURE	**Date:**

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

Fax all forms and other required information to: 866-441-4190