Phone: 866-310-7549
M–F 8AM–8PM ET
Novo Nordisk, Inc.
PO Box 370
Somerville, NJ 08876
Fax# 866-441-4190

Novo Nordisk Patient Assistance Program Application

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

Eligibility Requirements

You may qualify if:

- You are a US citizen or legal resident[a]
- Your total household income is at or below **400%** of the federal poverty level (FPL) (NeedyMeds website lists current FPL guidelines)
- You have **no** insurance
- You **participate in Medicare**
- You are **not enrolled** in, **plan to enroll in**, or **are eligible for** any other federal, state or government program, such as Medicaid, Low Income Subsidy (LIS), or Veterans (VA) Benefits

Have you lost your health insurance coverage due to COVID-19?

You may be eligible to receive a free 90-day supply of **insulin**[b]. Check the box at the top of page 2 to indicate you are applying for PAP **due to loss of insurance**.

If approved, you will receive free insulin medication for 90 days. Assistance can be extended for otherwise eligible patients who are not enrolled in or plan to enroll in, or are eligible for Medicaid coverage.

Insulin products include Tresiba®, Levemir®, NovoLog®, NovoLog® Mix 70/30, Fiasp®, and Novolin®.

[b]Eligibility is subject to Novo Nordisk's discretion, and Novo Nordisk reserves the right to modify or terminate the PAP at any time.

What to send?

- Completed application (signed and dated by both patient and prescriber)
- Proof of income

Applying for COVID-19 Conditional 90-day PAP?

- Completed application (signed and dated by both patient and prescriber)
- Proof of loss of **insurance coverage** (for example: job termination notice, job status change, proof of COBRA offer)
- **NO PROOF OF INCOME REQUIRED**

Resident of Minnesota?

- Completed application (signed and dated by both patient and prescriber)
- Proof of **income**
- State driver's license/identification card/Tribal card

Questions?

Phone: **866-310-7549** Monday-Friday 8AM–8PM ET

Fax: 866-441-4190

Patients: NovoPAP.com **HCPs:** NovoPAPHCP.com

[a]Including resident aliens (non-U.S. citizens currently residing in the United States). **Please note:** Minnesota residents may qualify for free insulin under the Minnesota Continuing Safety Net Program. Eligibility criteria include: individual must be a resident of Minnesota, must not be enrolled in medical assistance or MinnesotaCare, must not be enrolled in or plan on enrolling in Medicaid and/or Medicare Extra Help/LIS (if eligible), total household income must be at or below 400% of the federal poverty level (FPL), must not receive health care benefits through federally funded programs, with the exception of Medicare, must not be enrolled in or receive prescription drug benefits through the Department of Veterans Affairs, and those individuals with private prescription drug coverage must have an out-of-pocket cost for a 30-day supply of insulin greater than $75.

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Check one: ☐ New Application ☐ Re-Enrollment

Asterisks indicate required field. Do not leave blank.

☐ If patient is applying for PAP due to loss of health insurance coverage due to ***COVID-19***, check this box

PATIENT SECTION

Patient First & Last Name*:	Patient DOB*:
Patient's Street Address* (NO PO BOX): City, State, Zip: Note: MN residents who qualify for insulin under MN Insulin Safety Net Program will have their medication shipped directly to their home	
Home Phone*:	Mobile Phone*:
Gender: ☐ Male ☐ Female	Social Security Number*:
Patient Authorized Representative (Optional) (copy of representative photo ID required with application)	
Name:	Relationship:
Patient Signature:	Date:

You may provide the names of one or more individuals whom you authorize Novo Nordisk Patient Assistance Program to speak with on your behalf about your application, the status of your shipment of medication, or your participation in the Novo Nordisk Patient Assistance Program. Those people who you authorize to speak to Novo Nordisk PAP about you may provide or receive your personal information as necessary. Novo Nordisk does not accept paid advocacy groups as a patient-authorized representative. Novo Nordisk PAP is not affiliated with third parties who charge a fee for help with enrollment. These third parties may reference Novo Nordisk without permission. Patients are not required to use a third party who charges a fee to help with enrollment or refills.
To remove an authorized representative, please call Novo Nordisk PAP at 1-866-310-7549

Insurance

Do you have **any** form of **prescription drug coverage***? If **YES**, please check **ALL** that apply and complete information below. ☐ YES ☐ NO

Plan Name: Member ID: Phone#

- ☐ Employer-supplied or commercial/private drug coverage
- ☐ Medicaid Prescription Drug Coverage
- ☐ Medicare Part B (medical benefit that covers some prescription medications)
- ☐ VA or Military Benefits
- ☐ Medicare Part D (prescription drug coverage) **(include a copy of the front and back of your card)**
- ☐ Low Income Subsidy (LIS/Extra Help)

Not sure if you have Medicare Rx coverage? Medicare Part D Plan cards usually have "Medicare Rx" somewhere on the card. Medicare Advantage Plans with prescription coverage also have "Medicare Rx" somewhere on the card.

Income

Total **Yearly** Household Income $ **OR*** Total **Monthly** Household Income $

# of people living in your household* (include yourself, spouse/partner, all adults)	# of dependents (under 18 years of age)*

Include a copy of <u>one</u> of the following with your application*: (**NOTE:** Please provide proof of income for **ALL** members of the household.)

- ☐ 2 most current consecutive pay stubs or earning statements for all working members of the household
- ☐ Social Security Income, pension and other income statements, including interest or dividend statements
- ☐ Unemployment benefit statement/Worker's Compensation
- ☐ Retirement benefit statement (within 12 months)
- ☐ Last year's Federal Income Tax Return (1040, 1040x)
- ☐ W-2, 1099 (SSA, R, INT, DIV)
- ☐ Statement of Zero Income (if applicable)
- ☐ Pension benefit statement (within 12 months)

Patient Consent

Novo Nordisk respects your privacy. By agreeing to receive automated phone calls, you understand and agree that you are giving Novo Nordisk (and its partners who facilitate the Patient Assistance Program) express consent to receive automated and prerecorded phone calls from Novo Nordisk and its Patient Assistance Program partners on the phone number provided on your Patient Assistance Program application. You also understand that you will be asked to provide your social security number and date of birth during the prerecorded call in order to verify your identity, and that this information will not be retained by Novo Nordisk or its partners, but is simply to ensure that the appropriate individual is on the line. Your consent is optional and can be withdrawn at any time by calling us back and requesting to opt-out of automated phone calls.

Autodialed/Prerecorded phone calls*	☐ YES ☐ NO
Safety Information*: I give permission to share my personal information to Novo Nordisk, who may contact me with follow-up inquiries, and who may report my personal information to the health authorities to comply with applicable rules and regulations. *If no, the safety information will be reported to Novo Nordisk without providing my personal details.*	☐ YES ☐ NO

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Asterisks indicate required field. Do not leave blank.

PATIENT SECTION (continued)

Patient Information

Patient First & Last Name*:	Patient DOB*:

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)
- I am not enrolled in, plan to enroll in, or am eligible for Medicaid or Medicare Extra Help/Low Income Subsidy (LIS)
- 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, and will comply with any insurance carrier disclosure requirements, including my participation in this program.
- I have lost my healthcare insurance coverage due to COVID-19 (if applicable) 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 Authorized Legal Representative's Signature (no photocopies or power of attorney signature):

Patient Signature*: Date*:

Required for MEDICARE PART D ENROLLEE

I understand and agree:

- That if I am approved for the Patient Assistance Program (PAP), I will receive up to 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 all Medicare Part D applications must be processed by November 30th of each 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. Enrollment year:

Patient's or Authorized Legal 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 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 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.
- To access, obtain, use, disclose, receive, and maintain my Health Information for purposes of processing this Application, verifying the information provided in this Application, assisting in the identification of or determining eligibility under the Program and other patient assistance resources, investigating and verifying my insurance benefits, coordinating the dispensing and delivery of medication, and conducting the additional services described above and to run the Program, including internal business purposes.

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 cancellation 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 Authorized Legal 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 and provide evidence of the representative's legal authority to act on behalf of the patient:

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PRESCRIBER SECTION

Patient First & Last Name*:	Patient DOB*:
Other Medications*:	Known Drug Allergies*:

Prescriber Information

Name*:		Designation*:	
Street Address* Include Suite/Building# (NO PO BOX):			
Phone*:		SLN#*:	NPI*:
Fax*:	Office Contact:	Days Medication Delivery NOT Accepted:	

My signature below indicates that I have read, understood, and agree to the Health Care Practitioner Declaration below. Products are dispensed as written. (Handwritten/valid electronic signatures accepted; no photocopies, power or attorney, or stamped signatures allowed)

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. If I am a Nurse Practitioner, Physician Assistant, Pharmacist, or PharmD, I certify that I am authorized and eligible in the state within which I am currently practicing to prescribe these products, and that I have my supervising Physician's approval to do so if required by law. 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*: Date*:

Rx

Product	Max Dose/ Day (units)	Sig/Directions (e.g., QD, BID)	Formulation	Quantity
Fiasp® (insulin aspart injection) 100 U/mL			☐ Vial ☐ FlexTouch® ☐ Cartridge	
Tresiba® (insulin degludec injection) U-100			☐ Vial ☐ FlexTouch®	
Tresiba® (insulin degludec injection) U-200			☐ Vial ☐ FlexTouch®	
Levemir® (insulin detemir injection) 100 U/mL			☐ Vial ☐ FlexTouch®	
NovoLog® (insulin aspart injection) 100 U/mL			☐ Vial ☐ FlexPen® ☐ Cartridge	
Insulin Aspart Injection 100 U/mL (Unbranded Biologic*)			☐ Vial ☐ FlexPen® ☐ Cartridge	
NovoLog® Mix 70/30 (insulin aspart protamine and insulin aspart injectable suspension) 100 U/mL			☐ Vial ☐ FlexPen®	
Insulin Aspart Protamine and Insulin Aspart Injectable Suspension Mix 70/30 100 U/mL (Unbranded Biologic*)			☐ Vial ☐ FlexPen®	
Novolin® R (insulin human injection) 100 U/mL			☐ Vial	
Novolin® N (isophane insulin human suspension) 100 U/mL			☐ Vial	
Novolin® 70/30 (human insulin isophane suspension and human insulin injection) 100 U/mL			☐ Vial	
NovoFine® 32G (100 needles/box)				
NovoFine® Plus 32G (100 needles/box)				
NovoTwist® 32G (100 needles/box)				

All orders will be filled with up to a **120-day** supply unless otherwise indicated by the prescriber. Patients applying for PAP because of loss of health insurance coverage due to **COVID-19** will be provided a 90-day supply of insulin medication. Prescribers, please complete the application with max daily dose and sig accordingly. All reorder requests must be made directly by the prescriber to the Novo Nordisk Patient Assistance Program.

FlexPen®/FlexTouch® is used with Novo Nordisk disposable needles. **Needles will not be sent as part of the PAP order if they are not requested.**

*Unbranded Biologics of Novo Nordisk-branded analog insulins are available from Novo Nordisk Pharma, Inc. (NNPI).

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PRESCRIBER SECTION (continued)

Patient Information

Patient First & Last Name*:	Patient DOB*:

Rx (continued)

Product	Max Dose/ Day (units)	Sig/Directions (e.g., QD, BID)	Formulation	Quantity
Ozempic® (semaglutide) injection 1.5 mL Pen that delivers doses of 0.25 mg or 0.5 mg			☐ 1 pen pack*	
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 1 mg			☐ 1 pen pack*	
Victoza® (liraglutide) injection 1.2 mg 2 Pen pack			☐ 2 pen pack*	
Victoza® (liraglutide) injection 1.8 mg 3 Pen pack			☐ 3 pen pack*	
Xultophy® 100/3.6 (insulin degludec & liraglutide injection) 100 U/mL & 3.6 mg/mL			☐ 1 pen pack*	
GlucaGen® HypoKit® (glucagon for injection) 1 mg/mL			☐ 1 kit	
NovoPen Echo®			☐ 1 pen*	
Rybelsus® (semaglutide) tablets *Select **1** of the combination options*			☐ 3 mg / 7 mg ☐ 7 mg / 7 mg ☐ 7 mg / 14 mg ☐ 14 mg / 14 mg	60-day supply
			☐ 7 mg ☐ 14 mg	120-day supply

All orders will be filled with up to a **120-day** supply unless otherwise indicated by the prescriber. Patients applying for PAP because of loss of health insurance coverage due to **COVID-19** will be provided a 90-day supply of insulin medication. Prescribers, please complete the application with max daily dose and sig accordingly. All reorder requests must be made directly by the prescriber to the Novo Nordisk Patient Assistance Program.
*This item is used with Novo Nordisk disposable needles. **Needles will not be sent as part of the PAP order if they are not requested.**

What to Expect Next?

Mail or **fax** completed application and required documentation

Allow **2** business days for processing

If additional information is needed, you will receive a letter notifying you of the missing/incomplete information

If approved, allow an **additional 10–14** business days for delivery of medication to your prescriber's office.

MN residents, refer to approval letter for details.

You will be enrolled in the program for 12 months.

Medicare Part D patients will be enrolled through the end of the calendar year.