patient assistance program

Novo Nordisk Patient Assistance Program Refill/Reorder Request

novo nordisk®

Form must be submitted directly by the HCP and must include a cover letter/HCP letterhead to clearly identify HCP as the sender. All information must be completed unless otherwise indicated.

Fax: (866) 441-4190 Phone: (866) 310-7549

☐ Check this box if this request is for a new product or dose change

Applicant Information (One patient per form)	
Patient's Name:	Date of Birth: / /
Patient ID Number (if available):	Patient's State:

Licensed Health Care Practitioner Information	
Practitioner's Name:	State License Number:
Professional designation:	Expiration Date:
	NPI Number:
Practitioner's Shipping Street Address (no PO Box number):	
Practitioner's Shipping City, State, & Zip:	
Practitioner's Phone: ( ) -	Practitioner's Fax: ( ) -
Practitioner's E-mail (optional):	

Order Information		
Product Name	**Max Dose Per Day**	**Sig/Directions**

Needle Information (if applicable), check one

☐ NovoFine® Plus 32G 4mm (100/box) ☐ NovoFine® 32G 6mm (100/box) ☐ NovoTwist® 32G 5mm (100/box)

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, 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 (no photocopies or stamp signature):	Date:
PRACTITIONER SIGNATURE	

PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.

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