

FAX

To: 2867
Company:
Fax: 8772422215
Phone:

From:
Fax:
Phone:

NOTES:

**Patient Assistance Program
Novo Nordisk Inc.
PO Box 181640
Louisville, KY 40261**



**Phone: 866-310-7549
Fax: 866-441-4190**

Instructions:

- PLEASE BE SURE TO COMPLETE BOTH PAGES OF THIS FORM. **Incomplete applications will be returned.**
- **Submit the completed application with photocopies of the required proof of income to FAX 866-441-4190. Faxed requests must be sent from the healthcare practitioner's office.** Please allow up to 10 business days for processing. Applications may also be mailed to the address above. Allow an additional 7 days for processing if mailed.
- Approved patients will receive a 90-day supply of medication sent to the healthcare practitioner's office. Subsequent requests require a new application to be submitted. Income documentation is only required annually.
- Both the patient and healthcare practitioner will be notified in writing of approved and denied requests.
- Novo Nordisk reserves the right to modify or cancel this program at any time without notice. All requests are subject to product availability and patient eligibility verification.
- Please call Novo Nordisk toll-free at 1-866-310-7549 if you have questions.

Patient Information	
<input type="checkbox"/> New Application / Annual Renewal	<input type="checkbox"/> 90 Day Re-order
Patient's name: _____	Date of birth: ___/___/___
Patient's address: _____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Patient's phone number _____	Social Security number: _____ (required)
Eligibility Requirements	
A. Annual Household adjusted gross income from most recent federal tax return \$ _____ (Attach a copy of the patient's most recent Federal Tax Return (1040), Social Security Income (SSA 1099), Pensions, Interest, Retirement, Child Support, etc. This information is only required annually. It is not required for 90-day reorders.)	
B. Number of dependents in household (including self) _____	
C. Do you qualify for private, local, state or federal prescription reimbursement? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Please Attach Proof of Income Documents for all New Applications and Annual Renewals Incomplete Applications will be Returned	
<p>I reviewed the above Patient Assistance Program "the program" application completed by my physician and the information included on this form is accurate and correct. I certify that payment for the requested medication represents a financial hardship to me, and that I do not have access to third party reimbursement for the medication. I authorize my physician to disclose the information on this form to Novo Nordisk for purposes of administering the program. I understand that once my physician discloses this information to Novo Nordisk, the information will no longer be protected by federal privacy protection laws, but that Novo Nordisk will not further disclose the information included on this form to anyone else, other than agents or vendors that may be employed by Novo Nordisk to assist Novo Nordisk in administering the program or in sending me support literature and special offers. I understand that I have the right to receive a copy of this authorization from my physician. My physician will not make any further disclosures of the information on this form to Novo Nordisk after one year from the date of execution of this form. I understand that I can revoke this authorization at any time by writing to my physician and asking him or her not to further disclose my information. I understand that my physician will treat me even if I do not sign this form, but that I will not be able to participate in the program.</p>	
Patient's signature: _____	Date: _____
(No photocopies or power of attorney signature)	
<input type="checkbox"/> Yes, I would like to receive additional support literature and special offers from Novo Nordisk. I understand this will not affect my eligibility for the Patient Assistance Program.	
Patient's signature: _____	Date: _____
(No photocopies or power of attorney signature)	

Patient Information (Required for Valid Prescription)

Patient's name: _____ Date of birth: ___/___/___

Healthcare Practitioner Information

Practitioner's name: _____ State License #: _____ Exp Date: _____

Shipping Address: _____
(no P.O.Box number)

Phone number: _____ Fax number: _____

Email: _____

 I agree that, in addition to communications regarding PAP, the information I have provided may be used for Novo Nordisk business purposes, including but not limited to, providing me access to NovoMedLink™ resources and receiving facsimiles.**Prescription Information (Indicate Quantity Needed for 90 Day Supply)****Levemir® (insulin detemir [rDNA origin] injection)**

368712 Levemir® 10 mL vials Qty (vials) _____ Sig _____

643910 Levemir® FlexPen® (5x3 mL) ** Qty (boxes) _____ Sig _____

NovoLog® (insulin aspart [rDNA origin] injection)

750111 NovoLog® 10 mL vials Qty (vials) _____ Sig _____

633910 NovoLog® FlexPen® (5x3 mL) ** Qty (boxes) _____ Sig _____

NovoLog® Mix 70/30 (70% insulin aspart protamine suspension and 30% insulin aspart injection, [rDNA origin])

368512 NovoLog® Mix 70/30 10 mL vials Qty (vials) _____ Sig _____

369619 NovoLog® Mix 70/30 FlexPen® (5x3 mL) ** Qty (boxes) _____ Sig _____

Novolin® (human insulin [rDNA origin])

183311 Novolin® R Vials Qty (vials) _____ Sig _____

183411 Novolin® N Vials Qty (vials) _____ Sig _____

183711 Novolin® 70/30 Vials Qty (vials) _____ Sig _____

231321 Novolin® R InnoLet® (5x3 mL) ** Qty (boxes) _____ Sig _____

231421 Novolin® N InnoLet® (5x3 mL) ** Qty (boxes) _____ Sig _____

231721 Novolin® 70/30 InnoLet® (5x3 mL) ** Qty (boxes) _____ Sig _____

NovoFine® 30G Disposable Needles

185250 NovoFine® 30G Disposable Needles (100/box) Qty (boxes) _____ Use as Directed

Prandin® (repaglinide tablets)

008181 Prandin® 0.5 mg Qty _____ Sig _____

008281 Prandin® 1 mg Qty _____ Sig _____

008481 Prandin® 2 mg Qty _____ Sig _____

GlucaGen® HypoKit® (glucagon [rDNA origin] for injection)706515 GlucaGen® Hypokit® Qty (kits) _____
Sig _____**** This item is used with NovoFine® disposable needles. Needles will NOT be sent if not requested.**

My signature certifies that goods received from Novo Nordisk are for the use of the above named patient only. These goods will not be resold nor offered for sale, trade or barter and will not be returned for credit. I will not bill nor seek payment for the products from the patient or any third party payor, including, but not limited to, Medicaid or private insurance plans. Novo Nordisk reserves the right to recall the product when necessary.

Practitioner's signature: _____ Date: _____

(No photocopies or stamp signature)