NovoSecure™

Novo Nordisk Product Assistance Application

The Novo Nordisk Hemophilia and Rare Bleeding Disorder Product Assistance Program (PAP) provides medication to eligible applicants at no charge. If the applicant qualifies under the Novo Nordisk PAP guidelines, the prescribed dose of the requested medication(s) will be shipped to the applicant's home address.[a]

The Novo Nordisk PAP is free.

There is no registration charge or monthly fee for participating in the Novo Nordisk PAP.[b]

[a]Product limits vary.

[b]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 is a US citizen or legal resident**
- **Patient does not have prescription coverage, such as an HMO or PPO**
- **Patient has been prescribed a Novo Nordisk factor product for an indicated condition**
- **Patient's total household income must be at or below 400% of the federal poverty level (FPL)**
  - For further information on the FPL in your state, please visit the Families USA website at familiesusa.org/product/federal-poverty-guidelines
- **Patient cannot have or qualify for government insurance, including any federal, state, or local program, such as Medicare or Medicaid**
  - Patients who are eligible for Medicaid or Department of Veterans Affairs (VA) prescription benefits must have been denied enrollment, including exhaustion of all appeals, in order to be eligible for the PAP
  - If the patient is Medicare eligible but does not have Medicare Part D coverage, the patient must have applied for and been denied the Low Income Subsidy (LIS) from the Social Security Administration (SSA). To apply for LIS, please contact the SSA at 1-800-772-1213 (TTY 1-800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/

The Novo Nordisk PAP offers product assistance for Novo Nordisk Hemophilia and Rare Bleeding Disorder products that treat the following conditions:

- Congenital hemophilia A
- Congenital hemophilia B
- Congenital hemophilia A or B with inhibitors
- Congenital factor VII deficiency
- Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets
- Acquired hemophilia
- Congenital factor XIII A-subunit deficiency

See instructions starting on the next page.

PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.

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Instructions for Completing the Application

Complete ALL fields to avoid return of incomplete application.

- ❑ Make sure the application is signed by the prescriber AND dated (Part 1)
- ❑ Make sure the patient signs the certification section (Part 3)
- ❑ Include all documents required per the "**Documents Needed**" section below
- ❑ Return the completed application 1 of 3 ways:
  - Fax to 1-866-488-6576
  - Mail to NovoSecure™, PO Box 18648, Louisville, KY 40261-9961
  - Scan and email to mynovosecuresupervisor@mynovosecure.com

Documents Needed

- Proof of income required. Please provide one of the following items to show your adjusted gross annual household income:
  - ❑ Copy of the 2 most current paycheck stubs or earning statements for all working members of your household
  - ❑ Copy of last year's federal income tax return (1040)
  - ❑ Copy of Social Security income, pension, and other income statements, including interest or dividend statements
  - ❑ Copy of last year's (or most current) W-2 or 1099 form
  - ❑ Copy of unemployment benefits statement
- Medicaid, VA, or Extra help/LIS denial letter (As appropriate, denial letters must be provided with the application and be dated within 1 year of applying for the PAP)
- Prescription with exact quantity and assay limits

NOTE: New and annual renewal applications without proof of income documentation are considered incomplete.

What to expect next

Allow 7 to 10 business days for processing

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Part 1 of 3: Provider Information

Fax all forms and other required information to: 1-866-488-6576 or email to: mynovosecuresupervisor@mynovosecure.com.

FOR HEALTH CARE PROVIDER		
A	Patient's name:	Date of birth (MM/DD/YYYY):
	❑ Congenital hemophilia A ❑ Congenital hemophilia B ❑ Congenital hemophilia A or B with inhibitors ❑ Congenital factor VII deficiency ❑ Glanzmann's thrombasthenia with refractoriness to platelet transfusions ❑ Acquired hemophilia ❑ Congenital factor XIII A-subunit deficiency	

	Licensed Health Care Provider Information	
B	Provider's name:	State license number: Expiration date: NPI number:
	Provider's shipping street address (cannot ship to a PO box):	
	Provider's shipping City, State, and Zip:	
	Office phone:	Office fax:
	Office email:	Office contact name:
	Weekdays/times that deliveries are not accepted:	

C **Order Information** (include prescription and refill prescription for 23G [adult] or 25G [pediatric] infusion supplies if applicable; please submit an actual prescription with the strengths and assay limits)

Product name	Dose	Infusion instructions	Quantity to dispense

For questions regarding NovoSecure™, please call **1-844-NOVOSEC** (1-844-668-6732).

D **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™ PAP from any government program or third-party insurer. I also understand that eligibility under the PAP is subject to the discretion of Novo Nordisk 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.

Health Care Provider's Signature (no photocopies or power of attorney signature):	**Date:**
PROVIDER SIGNATURE	

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PO Box 18648
Louisville, KY 40261-9961
Phone: 1-844-668-6732

(Check all that apply)
☐ New Application
☐ Annual Renewal

Part 2 of 3: Patient Information

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

Fax all forms and other required information to: 1-866-488-6576 or email to: mynovosecuresupervisor@mynovosecure.com.

FOR PATIENT

A

Patient's name:	Date of birth (MM/DD/YYYY):
Sex: ☐Male ☐Female	Social Security number:
Allergies: (check all that apply) ❑ None ❑ Aspirin ❑ Codeine ❑ Sulfa ❑ Other	Ship drug to: ☐ Patient's home ☐ Prescribing HCP
Patient's street address (cannot ship to a PO box):	
Patient's City, State, and Zip:	
As part of this PAP, Novo Nordisk will provide me with refill reminders and notifications regarding program enrollment via phone calls. By checking the check box 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:	Mobile phone:
Email:	
Patient-authorized representative information (ie, parent or legal guardian)	
Name: Phone number:	Relationship to patient:

B

Annual household adjusted gross income from most recent federal tax return: $	
Number of people in household (including patient):	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
Has the patient received a final denial from Medicaid, including exhausting all appeals? ☐Yes ☐No
Is the patient enrolled in a Department of Veterans Affairs (VA) plan? ☐Yes ☐No
Has the patient received a final denial from the VA for prescription benefits, including exhausting all appeals? ☐Yes ☐No

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Part 3 of 3: Patient Certification and Authorization

Fax all forms and other required information to: 1-866-488-6576 or email to: mynovosecuresupervisor@mynovosecure.com.

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)
- I am not enrolled in, or actively seeking coverage from, any government, state, or federally funded medical or prescription benefit programs, including Medicare, Medicaid, Medigap, VA, DOD, and TRICARE, including Managed Medicaid programs or Medicaid as secondary insurance
- All information provided in this application is true and correct and that I will verify any of the information I provide to the PAP upon request by the PAP
- I will 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 any medication dispensed by the NovoSecure™ PAP from any third-party insurer, or any government, state, or federally funded medical or prescription benefit programs, including Medicare, Medicaid, Medigap, VA, DOD, and TRICARE, including Managed Medicaid programs or Medicaid as secondary insurance

I understand and agree:

- That my eligibility to participate in the PAP is subject to the discretion of Novo Nordisk 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 health insurance coverage 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
- That Product through the PAP is provided to me free of charge and that I have no obligation to purchase the Product due to my participation in the PAP

Patient's or Patient Representative's Signature (no photocopies or power of attorney signature):	**Date:**
PATIENT'S SIGNATURE	

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Fax all forms and other required information to: 1-866-488-6576 or email to: mynovosecuresupervisor@mynovosecure.com.

Patient Authorization to Share Health Information. I give permission to my health care providers, my health plan, and insurers to give health and other information about my use of 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 is 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 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 my Information will include my name, address, Social Security number, prescription coverage, prescription for medication(s), and insurance records
- That my Information will be used to determine whether I meet the requirements to participate in the PAP and 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 expires once I have notified NovoSecure™ that I have completed my treatment (unless a shorter time period is required by state law)
- 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 provider 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 providers, 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'S SIGNATURE	**Date:**

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

PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.