Cornerstones4Care™ Patient Assistance Program Application

The Cornerstones4Care™ Patient Assistance Program (PAP) provides medication to qualifying applicants at no charge. If the applicant qualifies under the Cornerstones4Care™ PAP guidelines, a 90-day supply of the requested medication(s) or device(s) will be shipped to **the applicant's licensed practitioner for dispensing.**

PATIENT ELIGIBILITY

☐ **Patient must be a US citizen or legal resident**

☐ **Patient cannot have or qualify for:**

- Any private prescription coverage, such as an HMO or PPO
- Any federal, state or local program such as Medicare or Medicaid. Exceptions include patients who have entered the coverage gap (donut hole) in Medicare Part D and patients who have applied for and been denied Medicare Extra Help/Low Income Subsidy (LIS) and are Medicare eligible
- Department of Veterans Affairs (VA) prescription benefits

☐ **Patient's total household income must be at or below 200% of the federal poverty level**

Household Size	Total Household Income for 48 Contiguous States & DC*
	200%
1	$22,980
2	$31,020
3	$39,060
4	$47,100
5	$55,140
6	$63,180
7	$71,220
8	$79,260
	For families with more than 8 persons, add $8,040 for each additional person

*Different guidelines apply for Alaska and Hawaii. For the complete federal poverty guidelines, please visit the Families USA Web site at http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html.

For a full list of products covered, please visit one of the following:

☐ Our company Web site at NovoNordisk-US.com (Patients/Patient Assistance Program section)

☐ Our health care professional Web site at NovoMedLink.com (Product Information/Patient Assistance Program section)

☐ Our patient Web site at Cornerstones4Care.com

Complete ALL fields to avoid return of incomplete application.

☐ Make sure the application is signed by the prescriber AND dated

☐ Remember to include disposable pen needle in the order information if applicable

☐ Make sure the patient signs the certification section AND, if a Medicare Part D enrollee, the patient should also sign the Medicare Part D certification

☐ Fax the completed application to (866) 441-4190

☐ Allow 7 to 10 business days for processing

Reset Form

Cornerstones4Care™ Patient Assistance Program Application

PO Box 181640
Louisville, KY 40261

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

☐ New Application
☐ Annual Renewal

Applicant Information

Patient's Name:	Date of Birth: / /
Gender: ☐ Male ☐ Female	Social Security Number: - -
Patient's Street Address:	
Patient's City, State, & ZIP:	
Phone: ( ) -	E-mail:
Attach a copy of the patient's most recent federal income tax return (1040). If not available, please provide other income documentation, such as: • Social Security Form SSA-1099 • Form W-2 • Pay stubs from the last month A notice of award letter must be provided with the patient's SSA-1099.	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 (800) 772-1213 (TTY 800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/.
Annual household adjusted gross income from most recent federal tax return: $_____ Number of people in household (including patient):_____	**New and annual renewal applications without proof of income documentation are considered incomplete.**
Does the patient qualify for private, local, or state 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

Medicare Part D enrollees must have entered the coverage gap (donut hole) for the relevant benefit year, before submitting this application. Please attach to this application a photocopy of documentation from the patient's Part D plan that the patient has entered the coverage gap (donut hole) for the relevant benefit year, such as a letter from the patient's Part D plan, a monthly statement of benefits, or an explanation of benefits (EOB).

Patient's signature or legal guardian's signature is required on page 3.

Licensed Health Care Practitioner Information

Practitioner's Name:	State License Number: Expiration Date:
Practitioner's Shipping Street Address (no PO Box number):	
Practitioner's Shipping City, State, & ZIP:	
Phone: ( ) -	Fax: ( ) -
E-mail:	

Order Information (include disposable pen needle order if applicable)

Product Name	How Supplied (circle)	Max Dose Per Day (in units)	Sig
	☐ Vial ☐ FlexPen®		
	☐ Vial ☐ FlexPen®		
	☐ Vial ☐ FlexPen®		

All prescriptions requested will be filled with a 90-day supply. A refill request must be made to receive an additional prescription.

Practitioner's signature is required on page 3.

Cornerstones4Care™ Patient Assistance Program Application

For Health Care Practitioner

Patient's Name:	**Date of Birth:** / /

My signature certifies that I am a licensed practitioner eligible under state law to prescribe, receive and dispense the requested medication(s) listed on the attached prescription(s), shipped from Novo Nordisk. I further certify all information provided in the Licensed Health Care Practitioner Information section is correct and agree to submit appropriate verification of such information upon Novo Nordisk's reasonable request. 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 Cornerstones4Care™ 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 Cornerstones4Care™ PAP from any government program or third party insurer and will not apply any Cornerstones4Care™ 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.

Practitioner's Signature (no photocopies or power of attorney signature): PRACTITIONER SIGNATURE	**Date:**

For Patient

I certify that I do not have the ability to pay for the medication(s) requested by my licensed health care practitioner on the attached prescription(s) and all information provided in this application is correct. I understand that the Cornerstones4Care™ Patient Assistance Program (PAP) is entitled at any time to request verification of any such information which I agree to provide. I consent that the Cornerstones4Care™ PAP may contact me for verification of my application status and receipt of the indicated medication(s). I understand that if approved, I am not eligible to seek reimbursement for the medication(s) requested from any government program or third party insurer. I understand eligibility under the Cornerstones4Care™ PAP is subject to Novo Nordisk's discretion and that Novo Nordisk reserves the right to modify or terminate the PAP at any time.

HIPAA AUTHORIZATION - I authorize my health care practitioner to provide Protected Health Information (PHI) (as such term is defined in the Health Insurance Portability and Accountability Act [HIPAA] and regulations thereunder, as well as other state or federally protected personal information), to the Cornerstones4Care™ PAP or third parties engaged, as required to assist Novo Nordisk in administering the Cornerstones4Care™ PAP. I authorize the Cornerstones4Care™ PAP to disclose my PHI to Centers for Medicare and Medicaid Services (CMS) for the purpose of verifying my Medicare Part D enrollment status and disclosing my enrollment in the Cornerstones4Care™ PAP to my Medicare Part D plan (if applicable). I understand that my PHI will consist of my name, address, social security number, income, prescription coverage, prescription for medication(s), financial documents and insurance records and will be used for purposes of determining my eligibility to participate in the Cornerstones4Care™ PAP and to ship appropriate medication(s) as prescribed by my licensed health care practitioner. I further understand that if my PHI is incomplete or completed PHI does not allow me to participate in the Cornerstones4Care™ PAP that I may be notified of such by the Cornerstones4Care™ PAP. I understand that upon the furnishing of my PHI to the Cornerstones4Care™ PAP, my PHI will not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. This authorization will extend for as long as I participate in the PAP and will thereafter expire. I may revoke this authorization at any time by providing written notice to Novo Nordisk at the address set forth above. My revocation will become effective on the date my written notice is received and processed by the Cornerstones4Care™ PAP and at such time I will no longer be qualified to receive medication assistance from the Cornerstones4Care™ PAP. I understand that I have the right to receive a copy of this authorization from my health care practitioner. I understand that my health care practitioner will treat me even if I do not sign this form, but that I will not be able to participate in the program.

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

***Required for* MEDICARE PART D ENROLLEE -** I understand that if I am approved for the Cornerstones4Care™ Patient Assistance Program (PAP), I will receive a 90-day supply of medication(s) and/or device(s) from the Cornerstones4Care™ PAP. I understand that I will continue to be approved to receive subsequent three-month supplies of medication(s) through the end of the current calendar year by submitting a new application, regardless of whether I no longer meet the eligibility criteria for the Cornerstones4Care™ PAP for that calendar year subsequent to my initial application. I agree 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 Cornerstones4Care™ PAP. I understand that I am not eligible to seek reimbursement for any medication dispensed by the Cornerstones4Care™ PAP from any government program or third party insurer and will not apply any Cornerstones4Care™ PAP medication(s) towards True-Out-Of-Pocket (TrOOP) costs.

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