Reset Form

Novo Nordisk Patient Assistance Program

P.O. Box 181640
Louisville, KY 40261
866-310-7549 • Fax: 866-441-4190

The Novo Nordisk Patient Assistance Program provides medication to qualifying applicants at no charge. If the applicant qualifies under the Novo Nordisk PAP guidelines, a three-month (3 month) supply of the requested medication(s) or device(s) will be shipped to the applicant's licensed practitioner for dispensing.

APPLYING TO THE Novo Nordisk PAP

Applicant Instructions:

- The applicant is required to complete sections 1.0, 1.1, 1.2, and 3.1 on the application. If you are a Medicare Part D enrollee you must also sign and date section 3.2. Also, if you are 65 years of age or older, you must also (i) provide proof that your are not eligible to receive Part D benefits, (ii) [provide proof that you have applied for and been denied the Low Income Subsidy ("LIS") from the Social Security Administration], or (iii) are enrolled in a Part D Plan and have hit the donut hole. In addition, those over 65 years of age must otherwise meet the program eligibility criteria set forth below in order to receive benefits under this program... Please note that if you are eligible to receive the LIS, you are not eligible to receive product under the Novo Nordisk Patient Assistance Program.
- The applicant must print his/her legal name exactly as it appears on the Social Security card issued to the applicant.
- To apply for LIS please contact the SSA at 800-772-1213 (TTY 800-325-0778) or go to www.socialsecurity.gov/prescriptionhelp/. Attach a photocopy of LIS denial letter to the Novo Nordisk PAP application.
- Please sign the certification sections in ink.

Healthcare Practitioner Instructions:

- The prescribing licensed healthcare practitioner is required to complete sections 2.0, 2.1, and 3.0. In addition the same licensed healthcare practitioner must complete the attached prescription sheet (Section 2.1) for a three-month supply of medication for all products except where indicated differently.
- Please include prescription for needles when applicable
- Please sign the certification section in ink.

DOCUMENTS TO SUBMIT TO NNI PAP

- Application completed by the applicant and prescribing licensed healthcare practitioner
- Prescription for a three-month or 90-day supply of medication from the licensed healthcare practitioner who signed the application
- Photocopy of applicant's letter from a Part D Plan that applicant is not eligible to receive Part D benefits.
- Photocopy of applicant's LIS denial letter (Medicare Part D enrollees only)
- Photocopy of documentation demonstrating that applicant has hit the donut hole (Part D enrollees only), such as an explanation of benefits, monthly statement, or letter from Part D Plan.
- Photocopy of applicant's most recent Federal Tax Return (1040), Social Security Income (SSA 1099), Pensions, Interest, Retirement, Child Support, etc. **(NOTE: Program will accept previous years 1040 form until May 1 of the following year; If your 1040 does not reflect your current Income please submit two recent paystubs for all working household members)**
- Patient currently receiving unemployment should submit:
  - Unemployment Letter
  - Last 3 months bank statements
- If patient or member of household is receiving Social Security benefits submit copy of the "Notice of Award" letter. **(NOTE: If you do not have this letter please contact your local Social Security office to request a letter stating when (date) you became eligible for benefits and what type of benefit you are receiving.)**
- Patient with zero income can submit a letter from their physician or social agency (food stamp approval) on physician or agency letterhead.

APPLICATION PROCESSING

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.

- Both the patient and healthcare practitioner will be advised in writing of approved and denied requests.
- If the applicant is approved, a three-month supply of the medication(s) or device(s) requested will be shipped to the licensed healthcare practitioner's office for dispensing. If you would like notification of the ship date for the requested medication, the licensed healthcare practitioner can obtain this notification by registering for the Novo Nordisk PAP free web portal at www.diabetespap.com.
- All incomplete applications will be sent to either the patient or licensed healthcare practitioner with instructions for completion.

PROGRAM ELIGIBILITY

- Patient cannot have or qualify for Veteran's Administration or any state or local programs.
- Patient cannot have or qualify for any private prescription coverage such as an HMO or PPO (with the exception of Medicare Part D).
- Patient's total household income must be at or below 200% of the Federal Poverty Level. See Chart on the following page.
- Patient must be a US Citizen or Legal Resident

Household Size	Total Household Income 48 Contiguous States & DC	Alaska	Hawaii
1	$21,660	$27,060	$24,920
2	$29,140	$36,420	$33,520
3	$36,620	$45,780	$42,120
4	$44,100	$55,140	$50,720
5	$51,580	$64,500	$59,320
6	$59,060	$73,860	$67,920
7	$66,540	$83,220	$76,520
8	$74,020	$92,580	$85,120
	For families with more than 8 persons, add $3,740 for each additional person.	For families with more than 8 persons, add $4,680 for each additional person.	For families with more than 8 persons, add $4,300 for each additional person.

Effective date: January 23, 2009

A new application must be submitted for each new product request; provided, however that Part D beneficiaries that have been accepted into the program need not only submit a new product request (not a new application) every three months to receive product for the remainder of the calendar year in which they were accepted into the program. Income documentation is only required annually.
All requests are subject to product availability and patient eligibility verification.
Novo Nordisk reserves the right to modify or cancel this program at any time without notice.

Patient Assistance Program
Novo Nordisk Inc.
PO Box 181640
Louisville, KY 40261
Phone: 866-310-7549
Fax: 866-441-4190

novo nordisk®

SECTION 1.0: Patient Information

☐ **New Application / Annual Renewal** ☐ **90 Day Re-order**

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

Patient's address: _____ Gender: Male ◯ Female ◯

_____

Patient's phone number _____ Social Security number: _____
(required)

Email: _____

SECTION 1.1: 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 insurance coverage? Yes ◯ No ◯

Please Attach Proof of Income Documents for all New Applications and Annual Renewals
Incomplete Applications will be Returned

SECTION 1.2: Medicare/Medicaid Information

Are you enrolled in Medicare? ◯ Yes ◯ No
Medicare ID #: _____

Are you enrolled in Medicaid? ◯ Yes ◯ No
Are you enrolled in a Medicare Part D plan? ◯ Yes ◯ No

Medicare Part D enrollees: You must have (i) applied for and been denied the Low Income Subsidy ("LIS") from the Social Security Administration ("SSA"), or (ii) hit the donut hole for the relevant benefit year, before submitting this application to the NNI PAP. To apply for LIS please contact the SSA at (800)772-1213 (TTY 800-325-0778) or go to **www.socialsecurity.gov/prescriptionhelp/**. Please attach (as applicable) to this application a photocopy of your LIS denial letter or documentation from your Part D Plan that you have hit the donut hole for the relevant benefit year, such as a letter from your Part D Plan, a monthly statement of benefits, or an Explanation of Benefits (EOB).

Printed in the U.S.A. 138967-DR5 September 2010

SECTION 2.0: Licensed 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.**

SECTION 2.1: Prescription Information (Indicate Quantity Needed for a three-month (3-month) Supply)

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

Levemir® (insulin detemir [rDNA origin] injection)		
368712	Levemir® 10 mL vials	Max. dose per day _____ Sig_____
643910	Levemir® FlexPen® (5x3 mL) **	Max. dose per day _____ Sig_____
NovoLog® (insulin aspart [rDNA origin] injection)		
750111	NovoLog® 10 mL vials	Max. dose per day _____ Sig_____
633910	NovoLog® FlexPen® (5x3 mL) **	Max. dose per day _____ 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	Max. dose per day _____ Sig_____
369619	NovoLog® Mix 70/30 FlexPen® (5x3 mL) **	Max. dose per day _____ Sig_____
Novolin® (human insulin [rDNA origin])		
183311	Novolin® R Vials	Max. dose per day _____ Sig_____
183411	Novolin® N Vials	Max. dose per day _____ Sig_____
183711	Novolin® 70/30 Vials	Max. dose per day _____ Sig_____
NovoFine® Disposable Needles		
185250	NovoFine® 30G Disposable Needles (100/box)	Qty (boxes)_____ Use as Directed
185189	NovoFine® 32G Tip (100/box)	Qty (boxes)_____ Use as Directed
Victoza® (liraglutide [rDNA origin] injection) Please see enclosed Important Safety Information, Prescribing Information, and Medication Guide for Victoza®		
402012	Victoza® 6mg/ml 2 x 3ml **	Max. dose per day _____ Sig_____
406013	Victoza® 6mg/ml 3 x 3ml **	Max. dose per day _____ 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.**

Printed in the U.S.A. 138967-DR5 September 2010

SECTION 3.0: Licensed Healthcare Practitioner Certification

My signature certifies that I am a licensed practitioner eligible under state law to prescribe, receive and dispense the requested medication(s) listed on this application, shipped from Novo Nordisk. I further certify all information provided in sections 2.0 and 2.1 are 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 pursuant to prescriptions provided by me for the applicant named in Section 1.0 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 Section 1.0 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 PAP records related to the applicant named in Section 1.0 of this application. I understand that I am not eligible to seek reimbursement for any medication dispensed by Novo Nordisk PAP from any government program or third party insurer and will not apply any Novo Nordisk PAP medication towards the applicant's TrOOP. I also understand that eligibility under the PAP is subject to Novo Nordisk's discretion and the Novo Nordisk reserves the right to modify or terminate the PAP at any time.

Practitioner's signature: _____ **Date:** _____

(No photocopies or stamp signature)

SECTION 3.1: Patient Certification

I certify that I do not have the ability to pay for the medication(s) requested by my licensed healthcare practitioner in Section 2.2 of this application and all information provided in section 1.0, 1.1, and 1.2 is correct. I understand that Novo Nordisk Patient Assistance Program is entitled at any time to request verification of any such information which I agree to provide. I consent that Novo Nordisk 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 any medication requested in Section 2.2 of this application from any government program or third party insurer. I understand eligibility under the Novo Nordisk 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 physician to provide Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act and regulations there under, "HIPAA", as well as other state or federally protected personal information), to Novo Nordisk PAP or third parties engaged, as required to assist Novo Nordisk in administering the Novo Nordisk PAP. I authorize Novo Nordisk 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 Novo Nordisk 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 Novo Nordisk PAP and to ship appropriate medication(s) as prescribed by my licensed healthcare practitioner. I further understand that if my PHI is incomplete or completed PHI does not allow me to participate in the Novo Nordisk PAP that I may be notified of such by the Novo Nordisk PAP. I understand that upon the furnishing of my PHI to the Novo Nordisk 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 Novo Nordisk PAP and at such time I will no longer be qualified to receive medication assistance from the Novo Nordisk PAP. I understand that I have the right to receive a copy of this authorization from my physician. 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.

OPT-IN

☐ I agree that the information I am providing may be used by Novo Nordisk, its affiliates or vendors to keep me informed about new products, services, special offers, or other opportunities that may be of interest to me, as they become available. THESE COMMUNICATIONS MAY CONTAIN MATERIAL MARKETING OR ADVERTISING NOVO NORDISK PRODUCTS, GOODS OR SERVICES. Novo Nordisk will take appropriate measures to protect my information. I can stop Novo Nordisk from sending me future communications by calling 1-877-744-2579, sending a brief note with my name and address to Novo Nordisk at 100 College Road West, Princeton, New Jersey 08540, or by clicking on the "unsubscribe" link which will be available in future email communications. By providing my information to Novo Nordisk and acknowledging below, I certify that I am at least eighteen (18) years of age.

Patient or Legal Guardian's signature: _____ **Date:** _____

(No photocopies or power of attorney signature)

SECTION 3.2: Medicare Part D Enrollee Certification

I understand that if I am approved for the Novo Nordisk PAP, I will receive a three-month (3-month) supply of medication(s) and/or device(s) from the Novo Nordisk 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 Novo Nordisk 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 Novo Nordisk PAP. I understand that I am not eligible to seek reimbursement for any medication dispensed by the Novo Nordisk PAP from any government program or third party insurer and will not apply any Novo Nordisk PAP medication(s) towards True-Out-Of-Pocket ("TrOOP) costs.

Patient or Legal Guardian's signature: _____ **Date:** _____

(No photocopies or power of attorney signature)