



Novo Nordisk Patient Assistance Program Application

Important Time-Saving Tips

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**.

PATIENT ELIGIBILITY:

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

Household Size	Total Household Income 48 Contiguous State & DC	Alaska	Hawaii
1	\$21,780	\$27,200	\$25,080
2	\$29,420	\$36,760	\$33,860
3	\$37,060	\$46,320	\$42,640
4	\$44,700	\$55,880	\$51,420
5	\$52,340	\$65,440	\$60,200
6	\$59,980	\$75,000	\$68,980
7	\$67,620	\$84,560	\$77,760
8	\$75,260	\$94,120	\$86,540
	For families with more than 8 person, add \$3,740 for each additional person	For families with more than 8 persons, add \$4,780 for each additional person.	For families with more than 8 persons, add \$4,390 for each additional person.

For a full list of products covered please visit:

- Our health care provider site at NovoMedLink.com **OR**
- Our patient site at Cornerstones4Care.com

Complete ALL fields to avoid return of incomplete application:

- Make sure application is signed by prescriber AND dated
- Patient signs the certification section AND, if Medicare Part D enrollee, the patient also signs the Medicare Part D certification
- Fax complete application to: **866-441-4190**
- Allow **7-10 business days** for processing



Novo Nordisk Patient Assistance Program

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

New Application Annual Renewal New Product or Dose Change

Applicant Information

Patient's name:	Date of birth: / /
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number: - -

Patient's street address:

Patient's city, state & zip code:

Patient's phone number: () -

Attach a copy of the patient's most recent Federal Tax Return (1040), Social Security Income (SSA 1099), Pensions, Interest, Retirement, Child Support, statements etc.

If you are Medicare eligible but do not have Medicare Part D coverage: You 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:

\$ _____

of dependents in household (including self): _____

New and Annual Renewal applications without proof of income documentation and/or incomplete applications will be returned.

Do you qualify for private, local, state or federal prescription insurance coverage? Yes No

Are you enrolled in Medicaid? Yes No

Are you enrolled in Medicare? Yes No

Medicare ID #:

Are you enrolled in a Medicare Part D Plan? Yes No

Medicare Part D enrollees: You must have hit the donut hole for the relevant benefit year, before submitting this application. Please attach to this application a photocopy of 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).

Licensed Healthcare Practitioner Information

Practitioner's Name:

State License #: Exp. Date:

Shipping street address: (no P.O. Box #)

Shipping city, state & zip code:

Phone: () -

Fax: ()

Prescription Information (include disposable pen needle prescription if applicable)

Product Name:	Max Dose Per Day:	Sig:	Days Supply:	# of Re-Orders (circle)		
			90 days	1	2	3
			90 days	1	2	3
			90 days	1	2	3

Patient's name:	Date of birth: / /
<p>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 Healthcare Practitioner Information section 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 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 be perform an on-site audit of 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 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 that Novo Nordisk reserves the right to modify or terminate the PAP at any time.</p>	
Practitioner's signature: (No photocopies or stamp signature)	Date:

I certify that I do not have the ability to pay for the medication(s) requested by my licensed healthcare practitioner on the attached prescription(s) and all information provided in this application is correct. I understand that Novo Nordisk Patient Assistance Program (PAP) 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 the medication(s) requested 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: (No photocopies or power of attorney signature)	Date:
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Required for MEDICARE PART D ENROLLEE - 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: (No photocopies or power of attorney signature)	Date:
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