Thank you for downloading this prescription assistance document from NeedyMeds. We hope this program will help you get the medicine you need.

**REMEMBER — Send your completed application to the address on the form, NOT to NeedyMeds.**

Did you know that NeedyMeds has thousands of other free resources?

Here's a look at more ways we can help you save money on medicine and healthcare costs. Each one can be found under the **"Healthcare Savings"** tab on our website:

- **Diagnosis-Based Assistance** — NeedyMeds lists thousands of assistance programs for almost any health condition. If you are going through chemo treatment for cancer, there are programs that can help with wig costs and scalp-cooling products. We also list resources for free diabetes testing supplies, caregiver lodging support, and much more.
- **Free, Low-Cost, and Sliding Scale Clinics** — This popular collection contains information on 18,000+ free, low-cost, and sliding scale medical, dental, mental health and substance abuse clinics across the U.S. It's a great resource if you need affordable medical treatment and don't know where to go.
- **Coupons, Rebates & More** — You can use the NeedyMeds website to find 2,600+ cost-saving opportunities for both prescription and over-the-counter drugs and medical supplies.
- **Medical Transportation** — Need help getting to the doctor's office or medical facility? You may be eligible for financial assistance if you meet certain requirements.

NeedyMeds also offers information on diagnosis-based camps and retreats, recreational programs, scholarships, government programs, $4 generic drug programs, and more.

Finally, I want to tell you about the NeedyMeds Drug Discount Card. Thousands of people use this free, anonymous, and easy-to-use tool to get the best price on their medications. Use the card to get discounts on lab tests and also to save 40% on durable medical equipment. To date, our drug discount card has saved patients over $300,000,000. Check out the following page to learn more.

Feel free to call our toll-free helpline if you have any questions. We can be reached at 1-800-503-6897 Monday-Friday, 9am-5pm Eastern Time.

Thank you for using NeedyMeds. Please let us know if we can do anything else to help you afford the costs of your healthcare.

Rich Sagall, MD
President, NeedyMeds

# Clip the card and save

NeedyMeds
NeedyMeds.org

**DRUG DISCOUNT CARD**

BIN: 020750
RX PCN: NMeds
RX GRP: PDFPDF
ID: NMNA019309901930

**Customer Care**
1-888-602-2978

**This is a drug discount program, not an insurance plan.**

NeedyMeds Drug Discount Card
www.needymeds.org

**Patient:** You may use this card at any of over 65,000 participating pharmacies to save on all prescription medicines. You cannot use this card with Medicare including part D, Medicaid, or any other state or federal programs unless you choose not to use your government-sponsored program. In addition, you cannot use this card with any health insurance program, but you can use it in place of your insurance if the card offers a better price. For questions call 1-888-602-2978 or visit www.drugdiscountcardinfo.com.

**Pharmacist:** Administered by Medical Security Company, LLC, Tucson, AZ.

**Pharmacy Help Desk**: 1-800-404-1031.

Powered by ScriptSave® WellRx

- Save up to 80% on medications*
- Use at over 65,000 pharmacies nationwide including all major chains
- Share the card with friends and family
- Use the card as often as needed
- Free, no fees or registration
- Never expires

## What will receive a discount?

All prescription medications are eligible for savings, including over-the-counter medicines and medical supplies written as a prescription, as well as human-equivalent pet medications with a prescription by a veterinarian.

Save up to 40% off durable medical equipment, including canes, crutches, splints, incontinence supplies and more. You can also save on diabetic supplies such as glucose meters, test strips, lancets and diabetic shoes. Visit www.needymeds.org/dme to learn more.

You can also save an extra 5% on affordable lab tests and online results. No doctor's order or insurance needed. Visit www.needymeds.org/L2L for more information.

## What if I have insurance?

Anyone can use the card, but it can't be combined with state or federal insurance. You can use the card instead of insurance if:

- A drug isn't covered by your insurance
- Your insurance has no drug coverage
- You have a high drug deductible
- You have met a low medicine cap
- The card offers a better price than your copay
- You are in the Medicare Part D donut hole

To obtain a plastic drug discount card, send a self-addressed, stamped envelope to:

NeedyMeds Drug Discount Card
50 Whittemore St.
Gloucester, MA 01930

*The card is not valid in combination with insurance plans, including Medicare, Medicaid or any state or federal prescription insurance. The card can be used only if you decide not to use your government-sponsored drug plan for your purchases.*

* Average savings of 60%, with potential savings of up to 80% or more (based on 2018 national program savings data). All prescription medications are eligible for savings.

**This is a drug discount program, not an insurance plan.** Discounts are available exclusively through participating pharmacies. The range of the discounts will vary depending on the type of prescription and the pharmacy chosen. This program does not make payments directly to pharmacies. Users are required to pay for all prescription purchases. Cannot be used in conjunction with insurance. You may call 1-888-602-2978 with questions or concerns or to obtain further information.

NovoSecure™

# Novo Nordisk Product Assistance Application

novo nordisk®

## 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<br>❑ Congenital factor VII deficiency ❑ Glanzmann's thrombasthenia with refractoriness to platelet transfusions<br>❑ Acquired hemophilia ❑ Congenital factor XIII A-subunit deficiency | |

| | Licensed Health Care Provider Information | |
|---|---|---|
| **B** | Provider's name: | State license number:<br>Expiration date:<br>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 | |

**PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.**

NovoSecure™

# Novo Nordisk Product Assistance Application

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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:<br>❑ 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:<br><br>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 |

**PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.**

NovoSecure™

# Novo Nordisk Product Assistance Application

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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** | |

**PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.**

NovoSecure™

# Novo Nordisk Product Assistance Application

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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.**