Patient Authorization Form | Rare Blood Disorders

Phone: 1-844-668-6732
Fax: 1-866-488-6576

Monday - Friday
8:00 AM to 8:00 PM ET

novo nordisk® | NovoCare®
Savings | Coverage | Support

* Indicates a required field

PATIENT INFORMATION

Patient first name:*		**Patient last name:***
DOB:*	**Patient phone:**	**Patient zip code:**
Primary caregiver first name:		**Primary caregiver last name:**
Primary caregiver phone:		**Relationship to patient:**

NOVOCARE® PROGRAM AND HIPAA AUTHORIZATION

I (or my parent/guardian/legal representative) hereby give permission for my (or the patients) health care providers, pharmacies, service providers and their contractors, heath plans, and health insurer(s) and their contractors, to disclose any necessary information, including, but not limited to, my (or the patients) name, income, prescription coverage, medical prescriptions, medical condition, financial documents, and health records ("Protected Health Information" or "PHI") to Novo Nordisk, its affiliates, service providers, and agents (collectively "Novo Nordisk"). I also give permission for NovoCare® to contact me regarding the program.

This Personal Information will be used for the purpose of enabling Novo Nordisk to administer the program "NovoCare®" by: (i) processing this Application: (ii) verifying my information; (iii) identifying and/or determining eligibility under NovoCare® and other patient assistance resources: (iv) investigating and verifying my insurance benefits; (v) coordinating the dispensing and delivery of medication; (vi) conducting additional services to run NovoCare®; and (vii) conducting quality assurance and/or other internal business activities in connection with NovoCare®.

I (or my parent/guardian/legal representative) further give permission to NovoCare® to use and disclose my (or the patient's) Personal Information to Health Care Providers, Insurer(s), caregivers, and Novo Nordisk, for the purposes described above. I understand that my health care providers, pharmacies, service providers and their contractors, health plans, and health insurer(s) and their contractors, may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I (or my parent/guardian/legal representative) understand and acknowledge that while NovoCare®, Novo Nordisk, and any authorized contractors acting on their behalf will make every effort to keep Personal Information private, once Personal Information is disclosed it may no longer be protected by federal privacy and security laws or applicable state laws. Specifically, I (or my parent/guardian/legal representative) acknowledge that once disclosed, Personal Information may be legally re-disclosed by authorized recipients unless otherwise prohibited by law.

I (or my parent/guardian/legal representative) understand that this authorization may be refused. I (or my parent/guardian/legal representative) may also revoke (withdraw) this NovoCare® HIPAA authorization at any time in the future by calling 1-844-668-6732 or writing to NovoCare® PO Box 592188, Orlando, FL 32859. Such refusal or future revocation will not affect my (or the patient's) commencement or continuation of treatment by healthcare providers, pharmacies, service providers, insurer(s), etc. However, if I (or my parent/guardian/legal representative revoke this authorization, there can be no further participation in the programs and/or services administered by NovoCare®. If I (or my parent/guardian/legal representative) revoke this authorization, NovoCare® will stop using or sharing my (or the patient's) Personal Information (except as necessary to end participation in the NovoCare® Program) but such revocation will not affect uses and disclosures of Personal information previously disclosed in reliance upon this authorization.

I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may receive a copy of this authorization which will remain valid for so long as necessary to facilitate the NovoCare® Program unless a shorter time period is required by federal or state law. I (or my parent/guardian/legal representative) also understand that NovoCare® may change or end at any time without prior notification.

☐ I am signing on behalf of the patient, and I hereby affirm that I have the legal right to do so, that I am the parent or legal guardian of the patient, or that I otherwise have valid power of attorney to act on behalf of the patient.

Patient/Legal Representative Signature:*	**Date:***
Legal representative:	**Relationship to patient:**

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NOVOCARE® SMS TEXTING AUTHORIZATION (OPTIONAL)

Yes, I have read and understand the NovoCare® SMS Terms of Use at RBDTextTerms.com and realize that Novo Nordisk or its partners may use my information to provide me with program status updates, quality monitoring, and as more fully explained in Novo Nordisk's Privacy Notice. I UNDERSTAND ANY CALLS OR TEXTS MAY BE GENERATED USING AN AUTOMATED TECHNOLOGY AND I DO NOT HAVE TO CONSENT TO RECEIVE COMMUNICATIONS VIA TELEPHONE OR TEXT MESSAGING BEFORE PURCHASING GOODS OR RECEIVING OTHER SERVICES FROM NOVO NORDISK.

☐ I consent

☐ I do not consent