norditropin® (somatropin) injection
5 mg, 10 mg, 15 mg, 30 mg pens

Patient Enrollment Form | Pediatric

Phone: 1-888-668-6444
Fax: 1-888-508-8200

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

novo nordisk® | NovoCare® Savings | Coverage | Support

* Indicates a required field ☐ New start ☐ Reauthorization ☐ Restarting treatment ☐ Transitioning from: _____

SERVICES REQUESTED

Access Support Requested:

☐ Prior Authorization support request. If PA approved, provide PA approval number_____ with dates from: ___/___/_____ to: ___/___/_____.

☐ Appeals support request

Additional Services:

☐ Norditropin® FlexPro® Device Training: ☐ In-person ☐ Virtual

☐ Starter Kit

☐ NovoCare® Savings Offer (if eligible). For complete terms and conditions, visit norditropinsavings.com.

PATIENT/INSURANCE INFORMATION

Patient first name:*	**Patient last name:***		**DOB (MM/DD/YYYY):*** / /
Gender†:* ☐ **Male** ☐ **Female**	Preferred language: ☐ English ☐ Spanish ☐ Other:		
Home address (No P.O. box):	City:	State:	**Zip:***
Shipping address (If different from Home Address):	City:	State:	**Zip:***
Primary guardian/caregiver:*		Relationship to patient:	
Primary Email:		Primary phone:	
Secondary guardian/caregiver:		Relationship to patient:	
Secondary Email:		Secondary phone:	
Primary medical insurance: (Please attach a copy of the insurance card if available)		Phone:	
Subscriber name:	Subscriber ID:	Policy/group #:	
Secondary medical insurance:		Phone:	
Subscriber name:	Subscriber ID:	Policy/group #:	
Primary pharmacy insurance: (Please attach a copy of the insurance card if available)		Phone:	
Rx # ID:	Rx Group #:	Rx PCN #:	Rx BIN #:

†Novo Nordisk and its partners recognize that patients may not identify as male or female. However, many insurance companies still require that one of these two fields be used for each of their members. Please indicate the gender on file with the patient's insurance company.

DIAGNOSIS

What is the primary diagnosis for which you are prescribing Norditropin® (somatropin) injection? *(required)**

Growth Hormone Deficiency (GHD):
☐ E23.0 - Hypopituitarism
☐ E23.1 - Drug-induced hypopituitarism
☐ E89.3 - Postprocedural hypopituitarism

Small for Gestational Age (SGA):
☐ P05.10 - Newborn born small for gestational age

Idiopathic Short Stature (ISS):
☐ R62.52 - Short stature (child)

Turner Syndrome:
☐ Q96.9 - Turner's syndrome, unspecified

Noonan Syndrome:
☐ Q87.1 - Congenital malformation syndromes predominantly associated with short stature

Prader-Willi Syndrome (PWS):
☐ Q87.11 - Congenital malformations, deformations and chromosomal abnormalities

Other diagnosis:
ICD-10 code and description: _____

PRESCRIPTION

☐ **Ongoing Prescription**

Norditropin® (somatropin) FlexPro® prefilled pen:
☐ 5mg ☐ 10mg ☐ 15mg ☐ 30mg

NovoFine® Needles:
☐ 32G Tip (6mm) disposable needles
☐ Autocover® 30G (8mm) disposable safety needles

☐ PenMate® reusable cover for needles:
☐ 1 ☐ 2

Directions:
Inject_____ mg SC daily _____ days per week _____ Days Supply _____ Refills

Preferred pharmacy:	Pharmacy Phone:	Pharmacy Fax:	
Pharmacy address:	City:	State:	Zip:

MEDICAL ASSESSMENT

Height (cm): _____ Date: ___/___/_____	GH stim test 1	GH stim test 2	IGF-1: _____
Weight (kg):* _____ Date: ___/___/_____	Date: ___/___/_____	Date: ___/___/_____	IGF BP-3: _____
Growth velocity (cm/y): _____	Agent: _____	Agent: _____	MRI has been completed: ☐ Yes ☐ No
Bone age: _____ Date: ___/___/_____	Results: _____	Results: _____	

PRESCRIBER AUTHORIZATION

Prescriber name:*			**License #:***
Practice name:	Office contact:		Preferred method of contact: ☐ Phone ☐ Fax ☐ Email
DEA #:	Tax ID #:		**NPI #:***
Phone:*	**Fax:***	**Email:***	
Address:*	**City:***	**State:***	**Zip:***

Prescriber release:* By signing below, I hereby certify that: (a) I am a licensed practitioner, in good standing under applicable state law; (b) the product being prescribed is to treat a diagnosis(es) consistent with indications and dosing described in the product's prescribing information; (c) the information I have provided on this enrollment form is, to the best of my knowledge, true, complete, and accurate in all respects; and (d) I have obtained the necessary authorization from the patient, or where appropriate the patient's parent, caregiver, and/or legal representative to use, disclose, share, and/or release the above-referenced information along with other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) for the sole purpose of providing patient assistance. Further, I appoint NovoCare®, on my behalf, to convey this prescription to the dispensing pharmacy. I will immediately notify Novo Nordisk Inc., its employees, or partners, including AssistRx, Inc. (collectively, "NovoCare®") if the above-named patient, or where appropriate the patient's parent, caregiver, and/or legal representative, revokes their consent to share their PHI with NovoCare®. I give you permission to contact me, or the above named patient/Caregiver, with any questions related to NovoCare®.

Prescriber signature (no signature stamps):*	**Date:*** / /

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