Patient Section

Novo Nordisk
Patient Assistance Program Application

The Novo Nordisk Patient Assistance Program (PAP) provides medication at no charge to applicants who qualify under the PAP guidelines. Requested medications or devices are shipped to a licensed health care professional for dispensing, up to a 120-day supply.

The Novo Nordisk PAP is free. There is no registration charge or monthly fee for participating in the Novo Nordisk PAP. All requests are subject to product availability and patient eligibility verification. Product is provided at no cost to the patient or the HCP, is not contingent on any product purchase, and the patient and HCP agree to not bill any third party for the product nor resell the product.

There will be a delay in processing unless each section of this form is fully completed. Please print legibly.

Check one: ☐ **New Application** ☐ **Re-Enrollment** ***Asterisks indicate required field. Do not leave blank.**

SECTION A

Patient First Name*:	Patient Last Name*:	
Patient Street Address* (NO PO BOX):		
City*:	State*:	Zip*:
Mobile Phone*:	Other Phone:	Email:
DOB*:	Gender: ☐ Male ☐ Female ☐ Prefer not to disclose	
Prescriber First Name*:	Prescriber Last Name*:	
Prescriber Phone*:		

Do you have any form of prescription drug coverage*?
If **YES**, please check **ALL** that apply and complete the information below*. ☐ Yes ☐ No

- ☐ Medicare (Part D) Prescription Coverage - ***must complete Section B***
- ☐ Medicare Part B (medical benefit that covers some prescription medications)
- ☐ VA or Military Benefits
- ☐ Medicaid Prescription Drug Coverage
- ☐ Medicare Low Income Subsidy (LIS/Extra Help)
- ☐ Employer-supplied or commercial/private drug coverage

Medicare Part D Enrollees – MUST COMPLETE ALL OF SECTION B

Not sure if you have Medicare Rx coverage? Do you have both commercial insurance and Medicare? Call the Benefits Coordination & Recovery Center toll-free at 1-855-798-2627 with questions about your benefits. Medicare Part D Plan cards usually have "Medicare Rx" somewhere on the card. Medicare Advantage Plans with prescription coverage also have "Medicare Rx" somewhere on the card.

SECTION B

Patient Medicare Prescription Drug Coverage (Part D) Enrollee Consent (if applicable)

I (or my parent/guardian/legal representative) agree that if I am (or the patient is) approved for PAP as a Medicare Part D Enrollee, Novo Nordisk or PAP may give my (or the patient's) Personal Information to the Centers for Medicare & Medicaid Services ("CMS") to confirm my (or the patient's) Medicare Part D enrollment status and let CMS and my (or the patient's) Medicare Part D plan know of this enrollment in PAP. Further, I (or my parent/guardian/legal representative) understand that upon approval, I (or the patient) will receive up to a 120-day supply of the medication(s) and/or device(s) from PAP through the end of this calendar year. I (or my parent/guardian/legal representative) agree that I (or the patient): (i) will not seek the requested Novo Nordisk medication(s) from my (or the patient's) Medicare Part D prescription plan while receiving them from PAP; (ii) am not eligible for reimbursement for any medication dispensed by PAP from any government program or third-party insurer; and (iii) and will not apply any PAP medication(s) toward my (the patient's) True-Out-of-Pocket ("TrOOP") costs.

Patient or Representative Signature*: Required ONLY if patient is a Medicare Part D enrollee	Date*:
PAP Application Enrollment Year:	Insurance ID*:

Phone: 866-310-7549 M–F 8am–8pm ET Novo Nordisk, Inc., PO Box 370, Somerville, NJ 08876 **Fax: 866-441-4190**

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025

Novo Nordisk
Patient Assistance Program Application

*Asterisks indicate required field. Do not leave blank.

First Name*:	Last Name*:	DOB*:

SECTION C

Income Verification Consent [Fair Credit Reporting Act (FCRA)] *REQUIRED:
SIGNATURE REQUIRED

PAP will perform an electronic income verification to process your application on your behalf.
Please sign below to provide consent.

I understand that I am providing "written instructions" under the Fair Credit Reporting Act ("FCRA"), authorizing PAP, Novo Nordisk, and its authorized vendor(s), on an ongoing basis as needed for the duration of my participation in programs administered by Novo Nordisk PAP, to obtain information from my credit profile or other information from the vendor through e-income verification, which will include a soft credit check, solely for the purpose of determining financial qualifications for programs administered by PAP. I understand that I must affirmatively agree to these terms in order to proceed in this financial screening process. I promise that any information, including financial and insurance information that I provide, is complete and true. I also understand that I may need to provide additional documentation and that additional eligibility requirements apply for the Novo Nordisk PAP.

Patient Signature*:

SECTION D

Consent to Collection of Health Information for PAP Purposes *REQUIRED
SIGNATURE REQUIRED

I (or my parent/guardian/legal representative) agree that Novo Nordisk and its data processors may collect, use, and disclose my (the patient's) health-related information, as described below (collectively, "Health Information") for participation in PAP:

- Individual health conditions, treatment, diseases, or diagnosis; Use or purchase of prescribed medication; Bodily functions, vital signs, symptoms, or measurements related to health; Diagnoses or diagnostic testing, treatment, or medication; Data that identifies a Consumer seeking health care services; Health-related data that have been derived or inferred from the above.
- We also collect any health-related information you disclose if you contact us, including information regarding adverse events.

If I (or my parent/guardian/legal representative) consent below, Novo Nordisk and its data processors will collect, use, and disclose my Health Information solely to facilitate my participation in PAP, including, as applicable, to: (i) process this Application; (ii) verify my information; (iii) identify and/or determine eligibility under PAP and other patient assistance resources; (iv) investigate and verify my insurance benefits; (v) coordinate the dispensing and delivery of medication; (vi) communicate with me about PAP; (vii) conduct additional services to run PAP; (viii) conduct quality assurance and/or other internal business activities in connection with PAP; and (ix) ensure compliance with laws and the rules of PAP (the "Purposes"). I (or my parent/guardian/legal representative) understand that Novo Nordisk may also combine or aggregate my Health Information and other personal information with data collected from other sources for the purpose of providing or administering PAP. **I understand that I (or my parent/guardian/legal representative) am not required to consent to processing of my Health Information for the Purposes. However, if I do not consent, I will not be able to participate in PAP, as collection of my Health Information is necessary for Novo Nordisk to facilitate my participation.** If I consent below, I have the right to withdraw consent at any time and may do so by emailing NNIPrivacy@novonordisk.com. For more information regarding our processing of personal information and Health Information, please see our Privacy Notice and our Consumer Health Data Privacy Notice.

Patient or Representative Signature*:	Date*:

Legal Representative name (if applicable):

Relationship to patient (if applicable):

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025

Novo Nordisk
Patient Assistance Program Application

*Asterisks indicate required field. Do not leave blank.

First Name*:	Last Name*:	DOB*:

SECTION E

HIPAA Authorization *REQUIRED
SIGNATURE REQUIRED

By signing below, I (or my parent/guardian/legal representative) hereby give permission for my (or the patient's) health care providers, pharmacies, health plans, health insurer(s) and their service providers and contractors (collectively, "My Providers") to disclose any and all necessary information, including, but not limited to, my (or the patient's) income, prescription coverage, medical prescriptions, medical condition, financial documents, and health records (collectively, "Health Information") to Novo Nordisk and its employees, affiliates, representatives, agents, service providers, and data processors, including the administrators of PAP (collectively, "Novo Nordisk"). This Health Information will be used for the purposes of enabling Novo Nordisk to administer PAP by: (i) processing this Application; (ii) verifying my information; (iii) identifying and/or determining eligibility under PAP and other patient assistance resources; (iv) investigating and verifying my insurance benefits; (v) coordinating the dispensing and delivery of medication; (vi) communicating with me about PAP; (vii) conducting additional services to run PAP; and (viii) conducting quality assurance and/or other internal business activities in connection with PAP. I (or my parent/guardian/legal representative) further give permission to Novo Nordisk to use and disclose my (or the patient's) Health Information to My Providers, and to my authorized representative (if I designate one in Section F, below) for the purposes described above. I (or my parent/guardian/legal representative) understand and acknowledge that while Novo Nordisk, and any authorized contractors acting on their behalf will make every effort to keep my Health Information private, once Health 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, Health 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 authorization at any time in the future by calling 1-866-310-7549 or writing to Novo Nordisk, Inc., PO Box 370, Somerville, NJ 08876. Such refusal or future revocation will not affect my (or the patient's) commencement or continuation of treatment by My Providers. **However, if I (or my parent/guardian/legal representative) refuse to sign or revoke this authorization, there can be no further participation in the programs and/ or services offered and administered through PAP.** If I (or my parent/guardian/legal representative) revoke this authorization, Novo Nordisk will stop using or disclosing my (or the patient's) Health Information (except as necessary to end participation), but such revocation will not affect uses and disclosures of my Health 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 one (1) year after the date of my signature, or for a shorter period dictated by applicable state law, unless revoked earlier. I (or my parent/guardian/legal representative) also understand that PAP may change or end at any time without prior notification. By signing below, I acknowledge that I have read and agree to the Patient Authorization above.

Patient or Representative Signature*:	Date*:
Legal Representative name (if applicable):	
Relationship to patient (if applicable):	

☐ I hereby affirm that I have the legal right to sign this authorization on behalf of the patient, 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.

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025

Novo Nordisk
Patient Assistance Program Application

*Asterisks indicate required field. Do not leave blank.

First Name*:	Last Name*:	DOB*:

SECTION F

Patient Authorized Representative (Optional)

You may provide the name of an individual (ie, spouse, sibling, child, etc.) whom you authorize the Novo Nordisk Patient Assistance Program to speak with on your behalf about your participation in the Novo Nordisk PAP. Those people who you authorize to speak to Novo Nordisk PAP about you may provide or receive your Health Information as necessary. Novo Nordisk does not accept paid advocacy groups as a patient-authorized representative. Novo Nordisk PAP is not affiliated with third parties who charge a fee for help with enrollment. These third parties may reference Novo Nordisk without permission. Patients are not required to use a third party who charges a fee to help with enrollment or refills.

If you would like to designate an authorized representative please provide their name, phone number, and relationship to you, and then sign below.

Authorized Representative Name:	Authorized Representative phone number:
☐ Family member/caregiver	☐ Other
Patient Signature:	Date:

To remove an authorized representative, please call Novo Nordisk PAP at 1-866-310-7549.

SECTION G

Telephone Consumer Protection Act ("TCPA") Communication Consent (Optional)

I (or my parent/guardian/legal representative) also agree to be contacted by Novo Nordisk and its employees, affiliates, representatives, agents, service providers, and data processors, including the administrators of PAP (collectively, "Novo Nordisk") by telephone calls and text messages made by or using an automated system or pre-recorded messages at the number(s) provided in this Application, to facilitate my participation in PAP for all non-marketing purposes. I (or my parent/guardian/legal representative) understand that I (or my parent/guardian/legal representative) may be asked to provide my (or the patient's) zip code and date of birth during pre-recorded calls in order to verify my (or the patient's) identity and that this information will not be retained by Novo Nordisk but is simply to verify identity. I (or my parent/guardian/legal representative) agree to notify PAP promptly if any of my numbers or addresses change in the future. I (or my parent/guardian/legal representative) understand that I can revoke this consent at any time. I (or my parent/guardian/legal representative) further acknowledge that I (or my parent/guardian/legal representative) have read and understand the Novo Nordisk Diabetes PAP SMS Terms of Use at www.NNPAPText.com and understand that I (or my parent/guardian/legal representative) can review the full Novo Nordisk Privacy Policy at https://www.novonordisk-us.com/privacy-notice.html. I (OR MY PARENT/GUARDIAN/LEGAL REPRESENTATIVE) UNDERSTAND THAT ANY CALLS OR TEXTS MAY BE GENERATED USING AN AUTOMATED SYSTEM OR PRE-RECORDED MESSAGES, AND I DO NOT HAVE TO CONSENT TO RECEIVE CALLS OR TEXTS BEFORE PURCHASING GOODS OR RECEIVING OTHER SERVICES FROM NOVO NORDISK. By signing below, I acknowledge that I have read and agree to the TCPA Communication Consent above.

Patient Signature*:
required if you consent

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025

Novo Nordisk
Patient Assistance Program Application

***Asterisks indicate required field. Do not leave blank.**

First Name*:	Last Name*:	DOB*:

SECTION H

Safety Information

If a safety concern is reported, I (or my parent/guardian/legal representative) understand that my Health Information and other personal information may be used by Novo Nordisk to contact me with follow-up inquiries and maintain records of adverse events and may be reported by Novo Nordisk to health authorities to comply with applicable rules and regulations.

SECTION I

Program Authorization & Certification *REQUIRED

Novo Nordisk Patient Assistance Program (PAP) Authorization (only needed if patient is applying to PAP)
I (or my parent/guardian/legal representative) hereby certify that I (or my parent/guardian/legal representative): (i) am over 18; (ii) am a United States citizen or legal resident; (iii) do not have the ability to pay for the medication(s) requested by my (or the patient's) health care provider on the attached prescription(s) and I meet the financial criteria detailed on this application to qualify for the program. I also certify that I am not enrolled in or eligible for any of the following: (i) Medicaid; (ii) Medicare Extra Help/Low Income Subsidy ("LIS"); (iii) federally funded insurance programs, with the exception of Medicare Part D; or (iv) receive prescription drug benefits through the U.S. Veterans Administration, other than Medicare Part D. Patients enrolled in Medicare Part D who satisfy the financial eligibility criteria qualify for the program, but once enrolled, must stay in the program through the end of the calendar year. I certify that (i) all information provided in this application is true and correct and that I (or my parent/guardian/legal representative) will verify any of the information provided to PAP upon request; (ii) I (or my parent/guardian/legal representative) will verify my (or the patient's) application status and receipt of the indicated medication(s) upon request by PAP; (iii) if approved to participate in PAP, I (or my parent/guardian/legal representative) will not seek reimbursement for the medication(s) requested from any government program or third-party insurer; and (iv) will comply with any insurance carrier disclosure requirements, including my participation in PAP; (v) I (or my parent/guardian/legal representative) authorize PAP to contact me (or my parent/guardian/legal representative) by mail, and email, and if I have provided my consent to the TCPA Communication Consent above by call/text at the contact information provided on this application so that PAP can provide me with access to the products which I am prescribed.
I (or my parent/guardian/legal representative) understand and agree: (i) my eligibility to participate in PAP is subject to Novo Nordisk's decision and that Novo Nordisk may modify or terminate PAP at any time; (ii) I may be required to provide proof of ineligibility for certain other prescription drug coverage programs in order to meet the eligibility requirements for PAP; and (iii) I am required to report any changes to my health insurance and prescription drug coverage to PAP. I (or my parent/guardian/legal representative) understand that the product received 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. In completing this Application, I confirm the following is complete and accurate and that I have read and agree to the Patient Authorization.

Patient or Representative Signature*:	Date*:

☐ I consent 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.

Legal Representative Name:

Relationship to patient:

Phone:

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025

Novo Nordisk
Patient Assistance Program Application

What to Expect Next:

- Please attach all additional documentation in your submission.
- Once received by the Novo Nordisk Patient Assistance Program (PAP), allow at least **2 business days** for processing.
- Your enrollment decision will be sent to you via SMS/mail after processing time.
- If you opted to receive pre-recorded phone calls (section G “TPCA”), you will also receive enrollment decisions via phone.
- Once approved, allow **up to 10-14 business days (21 days)** for delivery to your health care provider’s office.

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025

Novo Nordisk
Patient Assistance Program Application

*Asterisks indicate required field. Do not leave blank.

SECTION J

Patient First Name*:	Patient Last Name*:	DOB*:
Known Drug Allergies*:		
Patient Street Address*:		
City*:	State*:	Zip*:
Patient Email:		

SECTION K

Prescriber Information (All medication will be shipped to the prescriber. **No PO Box permitted.**)			
Prescriber First Name*:	Prescriber Last Name*:	Designation:	
Street Address*:			
Suite/Building/Floor#:	City*:	State*:	Zip*:
Phone*:	State License Number#*:	State Where Licensed:	
Fax*:	Office Contact:	Office Email:	
NPI*:			

SECTION L

Health Care Practitioner Declaration: "My signature certifies that I am a licensed health care practitioner eligible under state law to prescribe, receive, and dispense the requested medication(s) listed on the attached order, shipped from Novo Nordisk, and that I am not prohibited from participating in federally funded health care programs. If I am a Nurse Practitioner, Physician Assistant, Pharmacist, or PharmD, I certify that I am authorized and eligible in the state within which I am currently practicing to prescribe, receive, and dispense these products, and that I have my supervising Physician's approval to do so if required by law. **Note: Prescribing practitioner information must match practitioner's signature. I also certify that the product(s) being prescribed are to treat diagnosis(es) consistent with indication(s) and dosing described in the product's prescribing information.** I further certify that all information provided in the Licensed Health Care Practitioner Information section is correct. 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, at its discretion and with adequate notice, perform an on-site audit/review solely related to Novo Nordisk Patient Assistance Program (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 PAP or from any government program or third-party insurer and will not apply any Novo Nordisk medication, provided by PAP, towards the applicant's True-Out-Of-Pocket (TrOOP) costs. I also understand that eligibility under PAP is subject to Novo Nordisk's discretion and that Novo Nordisk reserves the right to modify or terminate PAP at any time. Finally, I certify that I receive no direct or indirect payments related to PAP."

Fiasp®, FlexPen®, FlexTouch®, NovoFine®, Novolin®, NovoLog®, NovoPen Echo®, Ozempic®, PenFill®, Rybelsus®, Tresiba®, and Xultophy® are registered trademarks of Novo Nordisk A/S. Novo Nordisk is a registered trademark of Novo Nordisk A/S.

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025

Prescriber Section

Novo Nordisk
Patient Assistance Program Application

*Asterisks indicate required field. Do not leave blank.

Patient First Name*:	Patient Last Name*:	DOB*:
Prescriber First Name*:	Prescriber Last Name*:	NPI*:

Product*	Max Dose/Day (units)	Sig/Directions*	Formulation* Cart = Cartridge			Qty
Insulin						
Tresiba® (insulin degludec) injection U-100			☐ Vial	☐ FlexTouch®		
Insulin Degludec Injection U-100 (UB)			☐ Vial	☐ FlexTouch®		
Tresiba® (insulin degludec) injection U-200			☐ FlexTouch®			
Insulin Degludec Injection U-200 (UB)			☐ FlexTouch®			
Fiasp® (insulin aspart) injection 100 U/mL			☐ Vial	☐ FlexTouch®	☐ Cart	
NovoLog® (insulin aspart) injection 100 U/mL			☐ Vial	☐ FlexPen®	☐ Cart	
Insulin Aspart Injection 100 U/mL **(UB)**			☐ Vial	☐ FlexPen®	☐ Cart	
Novolin® R (insulin human) injection 100 U/mL			☐ Vial			
Novolin® N (insulin isophane human) injectable suspension 100 U/mL			☐ Vial			
NovoPen Echo®		☐ 1 pen				
NovoLog® Mix 70/30 (insulin aspart protamine and insulin aspart) injectable suspension 100 U/mL			☐ Vial	☐ FlexPen®		
Insulin Aspart Protamine and Insulin Aspart Injectable Suspension Mix 70/30 100 U/mL **(UB)**			☐ Vial	☐ FlexPen®		
Novolin® 70/30 (insulin isophane human and insulin human) injectable suspension 100 U/mL			☐ Vial			
Needles						
NovoFine® 32G 6mm (100 needles/box)						

FlexPen®/FlexTouch® are used with Novo Nordisk disposable needles. **Needles will not be sent as part of the PAP order if they are not requested.**

By signing below, I acknowledge that I have read and agree to the Health Care Practitioner Declaration on page 7. Products are dispensed as written. (Handwritten/valid electronic signatures accepted; no photocopies, power of attorney, or stamped signatures allowed.)

Practitioner Signature*:	Date*:

Phone: 866-310-7549 M–F 8am–8pm ET Novo Nordisk, Inc., PO Box 370, Somerville, NJ 08876 **Fax: 866-441-4190**

Fiasp®, FlexPen®, FlexTouch®, NovoFine®, Novolin®, NovoLog®, NovoPen Echo®, Ozempic®, PenFill®, Rybelsus®, Tresiba®, and Xultophy® are registered trademarks of Novo Nordisk A/S. Novo Nordisk is a registered trademark of Novo Nordisk A/S.

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025

Novo Nordisk
Patient Assistance Program Application

*Asterisks indicate required field. Do not leave blank.

Patient First Name*:	Patient Last Name*:	DOB*:
Prescriber First Name*:	Prescriber Last Name*:	NPI*:

GLP-1 Receptor Agonists

†All orders will be filled with up to a 120-day supply unless otherwise indicated by the prescriber. Prescribers, please complete the application with max daily dose and sig/directions accordingly.

Product*	Sig/Directions*	Formulation*	Quantity†
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 0.25 mg or 0.5 mg (includes 6 needles)	0.25 weekly for 4 weeks, 0.5 mg for 2 weeks	☐ 1 pen pack (6 weeks)	1 box
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 0.25 mg or 0.5 mg (includes 6 needles)	0.5 mg weekly for 4 weeks	☐ 1 pen pack (4 weeks)	_____ box(es)
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 1 mg (includes 4 needles)	1 mg weekly for 4 weeks	☐ 1 pen pack (4 weeks)	_____ box(es)
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 2 mg (includes 4 needles)	2 mg weekly for 4 weeks	☐ 1 pen pack (4 weeks)	_____ box(es)
			Ozempic® Total: Total cannot exceed 4 boxes
Note: Ozempic® 0.25 mg is intended for treatment initiation only.			
Rybelsus® (semaglutide) tablets Select **1** of the options	1 tablet daily	☐ 3 mg/7 mg ☐ 7 mg/7 mg ☐ 7 mg/14 mg ☐ 14 mg/14 mg	60-day supply 60-day supply 60-day supply 60-day supply
		☐ 7 mg ☐ 14 mg	120-day supply 120-day supply
Note: Rybelsus® 3 mg is intended for treatment initiation only.			

GLP-1/Insulin Combination

Xultophy® 100/3.6 (insulin degludec & liraglutide) injection 100 U/mL & 3.6 mg/mL		☐ 1 pen pack	

Phone: 866-310-7549 M–F 8am–8pm ET Novo Nordisk, Inc., PO Box 370, Somerville, NJ 08876 **Fax: 866-441-4190**

Fiasp®, FlexPen®, FlexTouch®, NovoFine®, Novolin®, NovoLog®, NovoPen Echo®, Ozempic®, PenFill®, Rybelsus®, Tresiba®, and Xultophy® are registered trademarks of Novo Nordisk A/S. Novo Nordisk is a registered trademark of Novo Nordisk A/S.

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025

Novo Nordisk
Patient Assistance Program Application

What to Expect Next?

Please attach all additional documentation in your submission.

Allow at least **2 business days** for processing.

Enrollment decision will be sent via fax/mail to patient and health care provider. Patients who opted in to autodialed/prerecorded phone calls will also receive enrollment decisions via phone.

Once approved, allow **up to 10-14 business days (21 days)** for delivery of the medication to the address of the HCP office provided in this application. HCP office to contact patient to arrange pick-up.

Approved uninsured patients will be enrolled for 12 months. Medicare Part D patients are enrolled through the end of the calendar year and will need to reapply after October 15 for the following year.

Prescribers - Auto-Refill

(Currently not available for residents in ME/MN)

All new applicants will be automatically enrolled into our auto-refill program for all eligible medications[a].

[a]NovoPen Echo®, Ozempic®, NovoFine® Needles, and ALL 60-day supply combinations of Rybelsus® are NOT eligible for auto-refill.

If there is a change in address, patient medication or dosage, or if the patient is no longer under your care, please contact Novo Nordisk PAP immediately at 1-866-310-7549 so we can make any adjustments or cancel any future auto-refills. Any medication provided under PAP to qualified patients under your care must be delivered to, and accepted by, you/your office staff for further dispensing, only to that specific patient who qualified for PAP. Auto-refill will end when patient's enrollment period has expired. Refill/Change Request forms can be found at NovoPAPHCP.com

Medicare Part D will only receive refills providing medication that will last through the end of their enrollment.

☐ **Prescribers, check this box to opt out of auto-refills**
(Note: If opting out of auto-refill, prescribers are responsible for initiating any future refills.)

Phone: 866-310-7549 M–F 8am–8pm ET Novo Nordisk, Inc., PO Box 370, Somerville, NJ 08876 **Fax: 866-441-4190**

Fiasp®, FlexPen®, FlexTouch®, NovoFine®, Novolin®, NovoLog®, NovoPen Echo®, Ozempic®, PenFill®, Rybelsus®, Tresiba®, and Xultophy® are registered trademarks of Novo Nordisk A/S. Novo Nordisk is a registered trademark of Novo Nordisk A/S.

© 2025 Novo Nordisk All rights reserved. NNIPAP_13_Jul2025