Novo Nordisk **Patient Assistance Program Refill/Reorder/Change Request**

Health Care Practitioner: Use this form to request a refill, add a new medication, request a change in medication, change the dosage of a current medication, or to update your health care practitioner contact information.

This form must be submitted directly by the HCP and must include a cover letter/HCP letterhead to clearly identify HCP as the sender.

Check all that apply:

☐ **Refill request** ☐ **New medication** ☐ **Medication change** ☐ **HCP address or information change** ☐ **Other**

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

Section J: Patient Information

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

Section K: Health Care Practitioner Information

Licensed Health Care Practitioner 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

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."

PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS.

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

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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 1. Products are dispensed as written. (Handwritten/valid electronic signatures accepted; no photocopies, power of attorney, or stamped signatures allowed.)

Practitioner Signature*:	Date*:

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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	

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