

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

SERVICES REQUESTED	Access Support Requested: <input type="checkbox"/> Prior Authorization support request. If PA approved, provide PA approval number _____ with dates from: ____/____/____ to: ____/____/____ <input type="checkbox"/> Appeals support request			
	Additional Services: <input type="checkbox"/> JumpStart™ ^{ab} request <input type="checkbox"/> Sogroya® Device Training: <input type="checkbox"/> In-person <input type="checkbox"/> Virtual <input type="checkbox"/> Starter Kit <input type="checkbox"/> NovoCare® Savings Offer (if eligible). For complete terms and conditions, visit SogroyaSavingsEligibility.com .			
	<small>^a Terms and conditions of JumpStart™ require active, timely prescriber support of Prior Authorization and/or Appeal documentation submission.</small>			
	<small>^b Patients who have been prescribed Sogroya® for an FDA-approved indication and who have commercial insurance may be eligible to receive a limited supply of free product from JumpStart™. Patient is not eligible if he/she participates in or seeks reimbursement or submits a claim for reimbursement to any federal or state health care program with prescription drug coverage, such as Medicaid, Medicare, Medigap, VA, DOD, TRICARE, or any similar federal or state health care program. JumpStart™ product is provided at no cost to the patient or the HCP, is not contingent on any product purchase, and the patient and HCP must not: (1) bill any third party for the free product, or (2) resell the free product. No purchase necessary.</small>			
PATIENT/INSURANCE INFORMATION	Patient first name:* _____		Patient last name:* _____	
	Gender:* <input type="checkbox"/> Male <input type="checkbox"/> Female Preferred language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		DOB (MM/DD/YYYY):* ____/____/____	
	Home address (No P.O. box): _____		City: _____	State: _____
	Shipping address (If different from Home Address): _____		City: _____	State: _____
	Email: _____		Primary phone: _____	
	Alternate contact name: _____		Relationship to patient: _____	
	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 #: _____
<small>* 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.</small>				
DIAGNOSIS	Adult GHD: (required)* Due to: (required)* <input type="checkbox"/> Childhood onset <input type="checkbox"/> Adult onset <input type="checkbox"/> E23.0 - Hypopituitarism <input type="checkbox"/> E23.1 - Drug-induced hypopituitarism <input type="checkbox"/> E89.3 - Postprocedural hypopituitarism			
	Other diagnosis: _____ ICD-10 code and description: _____			
PRESCRIPTION	If requesting JumpStart™ please select both Prescription fields (required)* <input type="checkbox"/> JumpStart™ Prescription <input type="checkbox"/> Ongoing Prescription			
	Sogroya® (somapacitan-beco) prefilled pen: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg		NovoFine® Needles: <input type="checkbox"/> 32G Tip (6mm) disposable needles <input type="checkbox"/> PenMate® reusable cover for needles: <input type="checkbox"/> Autocover® 30G (8mm) disposable safety needles <input type="checkbox"/> 1 <input type="checkbox"/> 2	
	Directions: Inject _____ mg SC once weekly _____ Days Supply _____ Refills			
	Preferred pharmacy: _____		Pharmacy Phone: _____	Pharmacy Fax: _____
Pharmacy address: _____		City: _____	State: _____	Zip: _____
MEDICAL ASSESSMENT	Initial GH Stimulation Testing for CO-GHD; please include copies of test results if available			
	GH stim test 1	GH stim test 2	IGF-1 #1: _____	MRI has been completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date: ____/____/____	Date: ____/____/____	IGF-1 #2: _____	Date of MRI: ____/____/____
	Agent: _____	Agent: _____	Results: _____	
PRESCRIBER AUTHORIZATION	Prescriber name:* _____		License #:* _____	
	Practice name: _____		Office contact: _____	
	DEA #: _____		Preferred method of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email	
	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:* ____/____/____