SOGROYA® somapacitan-beco injection 5mg | 10mg | 15mg

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:

☐ JumpStart™[ab] request
☐ Sogroya® Device Training: ☐ In-person ☐ Virtual
☐ Starter Kit
☐ NovoCare® Savings Offer (if eligible). For complete terms and conditions, visit SogroyaSavingsEligibility.com.

[a] Terms and conditions of JumpStart™ require active, timely prescriber support of Prior Authorization and/or Appeal documentation submission.

[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.

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 Sogroya® (somapacitan-beco) injection? *(required)* *

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

Other diagnosis:
ICD-10 code and description: _____

PRESCRIPTION

If requesting JumpStart™, please select both Prescription fields *(required)* * ☐ **JumpStart™ Prescription** ☐ **Ongoing Prescription**

Sogroya® (somapacitan-beco) prefilled pen:
☐ 5mg ☐ 10mg ☐ 15mg

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

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

Directions:
Inject_____ mg SC once weekly _____ 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: _____	
Bone age: _____ Date: ___/___/___	Results: _____	Results: _____	MRI has been completed: ☐ Yes ☐ No

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:*** / /