

Patient Authorization Form | Rare Blood Disorders

Phone: 1-844-668-6732
 Fax: 1-866-488-6576

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



NovoCare[®]
 Savings | Coverage | Support

* Indicates a required field

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PATIENT INFORMATION

Patient first name: *	Patient last name: *	DOB: * / /
Patient zip code: *		
Caregiver first name:	Caregiver last name:	Caregiver DOB: / /
Relationship to patient:	Primary phone: *	Primary Email: *

I prefer to be contacted by: Phone Email SMS Text (must also opt in below if selecting this option)

NOVOCARE[®] HIPAA Authorization*

BOTH CHECK BOX AND 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, service providers and their contractors, health plans, and health insurer(s) and their contractors to disclose any and all necessary information, including, but not limited to, my (or the patient's/ caregiver's) prescription coverage, medical prescriptions, medical condition, and health records ("Personal Information") to Novo Nordisk, its affiliates, service providers, agents, and representatives, including service providers for NovoCare[®] Patient Support Hub (NovoCare[®]) (collectively "Novo Nordisk") and the local community liaison. This Personal Information aids Novo Nordisk in administering NovoCare[®] by: (i) processing this Authorization Form; (ii) verifying my information; (iii) identifying and/ or determining eligibility under NovoCare[®] and other patient assistance resources; (iv) investigating and verifying my insurance benefits; (v) coordinating the dispensing and delivery of medication; (vi) contacting me about NovoCare[®] services (through Novo Nordisk's Rare Blood Community Liaisons or service providers administering NovoCare[®]) (vii) providing me with resources and information in connection with support programs and/ or services administered by NovoCare[®]; (viii) conducting additional services to run NovoCare[®]; and (ix) conducting quality assurance and/or other internal business activities in connection with NovoCare[®]. I (or my parent/guardian/legal representative) further give permission to NovoCare[®] to use and disclose my (or the patient's) Personal Information to Health Care Providers, Insurer(s), and caregivers 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 Personal Information private, once Personal 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, Personal Information may be legally redisclosed 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 1-844-668-6732 or writing to NovoCare[®] P.O. Box 592188, Orlando, FL 32859. Such refusal or future revocation will not affect my (or the patient's) commencement or continuation of treatment by health care providers, pharmacies, service providers, insurer(s), etc. 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 administered by NovoCare[®]. If I (or my parent/guardian/legal representative) revoke this authorization, Novo Nordisk will stop using or sharing disclosing my (or the patient's) Personal Information (except as necessary to end participation), but such revocation will not affect uses and disclosures of Personal 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 unless revoked earlier. I (or my parent/guardian/legal representative) also understand that NovoCare[®] 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/guardian/legal representative Signature:	Date: / /
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* Indicates a required field

NOVOCARE[®] Program Authorization*

BOTH CHECK BOX AND SIGNATURE REQUIRED

I (or my parent/guardian/legal representative) hereby certify that I (or my parent/guardian/legal representative): (i) am over 18; and (ii) am a United States citizen or legal resident; and (iii) fulfill all the requirements to participate in NovoCare[®] programs. In completing this Authorization Form, I confirm that the information provided is complete, true, and accurate that I (or my parent/guardian/legal representative) will verify any of the information provided to NovoCare[®] upon request. I understand the local Community Liaison will serve as my main point of contact, and I understand they will reach out to me by phone, text or email based on my indicated preferred contact method for purposes of providing the support programs needed as identified by me or my HCP, to talk about life with Hemophilia and to keep me informed about Hemophilia related products, support offerings, and news related to Hemophilia.

Patient/guardian/legal representative Signature:*

Date:* / /

For more information regarding our processing of personal information and Health Information, please see our Privacy Notice <https://www.novonordisk-us.com/privacy-notice.html> and our Consumer Health Data Privacy Notice.

NOVOCARE[®] Program SMS Text Authorization (OPTIONAL)

Yes, I have read and understand the NovoCare[®] SMS Terms of Use at [RBDTextTerms.com](https://www.novonordisk-us.com/rbdtextterms.com) and realize that Novo Nordisk or its partners may use my information to provide me with program status updates, quality monitoring, and as more fully explained in Novo Nordisk's Privacy Notice.

I UNDERSTAND ANY CALLS OR TEXTS MAY BE GENERATED USING AUTOMATED TECHNOLOGY AND I DO NOT HAVE TO CONSENT TO RECEIVE COMMUNICATIONS VIA TELEPHONE OR TEXT MESSAGING BEFORE PURCHASING GOODS OR RECEIVING OTHER SERVICES FROM NOVO NORDISK.

- I consent
- I do not consent