

\* 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:**

Norditropin® FlexPro® Device Training:  In-person  Virtual

Starter Kit

NovoCare® Savings Offer (if eligible). For complete terms and conditions, visit [norditropinsavings.com](http://norditropinsavings.com).

**PATIENT/INSURANCE INFORMATION**

**Patient first name:**\* \_\_\_\_\_ **Patient last name:**\* \_\_\_\_\_ **DOB (MM/DD/YYYY):**\* \_\_\_\_/\_\_\_\_/\_\_\_\_

**Gender:**\*  Male  Female Preferred language:  English  Spanish  Other:

Shipping address 1 (No P.O. box): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip:\* \_\_\_\_\_

Shipping address 2: \_\_\_\_\_ 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 Norditropin® (somatropin) injection? (required)\***

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

Small for Gestational Age (SGA):  P05.10 - Newborn born small for gestational age  Idiopathic Short Stature (ISS):  R62.52 - Short stature (child)

Turner Syndrome:  Q96.9 - Turner's syndrome, unspecified

Noonan Syndrome:  Q87.1 - Congenital malformation syndromes predominantly associated with short stature

Prader-Willi Syndrome (PWS):  Q87.11 - Congenital malformations, deformations and chromosomal abnormalities

Other diagnosis: \_\_\_\_\_

ICD-10 code and description: \_\_\_\_\_

**PRESCRIPTION**

**Ongoing Prescription**

Norditropin® (somatropin) FlexPro® prefilled pen:  5mg  10mg  15mg

Directions: \_\_\_\_\_

Inject \_\_\_\_\_ mg SC daily \_\_\_\_\_ days per week \_\_\_\_\_ Days Supply \_\_\_\_\_ Refills

NovoFine® Needles:  32G Tip (6mm) disposable needles  PenMate® reusable cover for needles:  1  2

Autocover® 30G (8mm) disposable safety needles

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: \_\_\_\_\_ MRI has been completed:  Yes  No

Bone age: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Results: \_\_\_\_\_ Results: \_\_\_\_\_

**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:**\* \_\_\_\_/\_\_\_\_/\_\_\_\_