

Patient Enrollment Form

Phone: 1-888-809-3942
Fax: 1-844-667-3475

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



NovoCare[®]
Savings | Coverage | Support

* Indicates a required field

PATIENT/INSURANCE INFORMATION

Patient first name:*		Patient last name:*		DOB (MM/DD/YYYY):*	
Gender [†] :* <input type="checkbox"/> Male <input type="checkbox"/> Female		Preferred language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			
Home address:*					
City:*		State:*	Zip:*	Preferred phone:*	
Primary guardian/caregiver (if patient is younger than 18):				Relationship to patient:	
Please fill out section below or attach a copy of the insurance card(s) if available					
Primary pharmacy insurance:*				Phone:	
Rx # ID:*		Rx Group #:		Rx PCN #:	
Rx BIN #:		Employer name:			
Secondary pharmacy insurance:				Phone:	
Rx # ID:		Rx Group #:		Rx PCN #:	
Rx BIN #:		Employer name:			
[†] 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 AND CLINICAL INFORMATION

Only complete this section if you are requesting full NovoCare[®] enrollment

Wegovy[®] (semaglutide) injection <input type="checkbox"/> 0.25 mg/0.5 mL <input type="checkbox"/> 0.5 mg/0.5 mL <input type="checkbox"/> 1.0 mg/0.5 mL <input type="checkbox"/> 1.7 mg/0.75 mL <input type="checkbox"/> 2.4 mg/0.75 mL Days supply: <input type="checkbox"/> 28 <input type="checkbox"/> 56 <input type="checkbox"/> 84 <input type="checkbox"/> Other: _____	Wegovy[®] (semaglutide) tablet <input type="checkbox"/> 1.5 mg <input type="checkbox"/> 4 mg <input type="checkbox"/> 9 mg <input type="checkbox"/> 25 mg Days supply: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Saxenda[®] (liraglutide) injection 3 mg Days supply: <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> Other: _____
What is the diagnosis for which you are prescribing Wegovy[®] or Saxenda[®]?		
Common obesity codes: <input type="checkbox"/> E66.0 - Obesity due to excess calories <input type="checkbox"/> E66.01 - Morbid (severe) obesity due to excess calories <input type="checkbox"/> E66.09 - Other obesity due to excess calories <input type="checkbox"/> E66.1 - Drug-induced obesity	<input type="checkbox"/> E66.2 - Morbid (severe) obesity with alveolar hypoventilation <input type="checkbox"/> E66.3 - Overweight <input type="checkbox"/> E66.8 - Other obesity <input type="checkbox"/> E66.9 - Obesity, unspecified (can be used 1x for initial visit only)	BMI codes: <input type="checkbox"/> Z68.____ - Please write in first two digits of BMI value between 30.0 and 39.9 <input type="checkbox"/> Z68.41 - BMI 40.0-44.9 <input type="checkbox"/> Z68.42 - BMI 45.0-49.9 <input type="checkbox"/> Z68.43 - BMI 50.0-59.9 <input type="checkbox"/> Z68.44 - BMI 60.0-69.9
<input type="checkbox"/> Z68.45 - BMI 70.0 or greater <input type="checkbox"/> Z68.54 - BMI pediatric, greater than or equal to 95th percentile for age		Other diagnosis: ICD-10 code: _____
Is this request for initiation or continuation of therapy? <input type="checkbox"/> Initiation <input type="checkbox"/> Continuation <input type="checkbox"/> Restart		Initial BMI:

HEALTH CARE PROVIDER AUTHORIZATION

Prescriber name:*			State license #:*		
Practice name:		Office contact:		Preferred method of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email	
NPI #:*	Phone:*	Fax:*	Email:*		
Address:*		City:*		State:*	Zip:*
Health care provider release:* By signing below, I hereby certify that: (a) I am a licensed practitioner, in good standing under applicable state law; (b) in my medical judgment, I have determined that the product being prescribed is to treat a diagnosis(es) consistent with indications, dosing, and appropriate uses as 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. 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 [®] .					
Health care provider signature (no signature stamps):*					Date:*