

\* 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<sup>TM</sup> request  
 Sogroya<sup>®</sup> Device Training:  In-person  Virtual  
 Starter Kit  
 NovoCare<sup>®</sup> Savings Offer (if eligible). For complete terms and conditions, visit [SogroyaSavingsEligibility.com](http://SogroyaSavingsEligibility.com).

<sup>a</sup> Terms and conditions of JumpStart<sup>TM</sup> require active, timely prescriber support of Prior Authorization and/or Appeal documentation submission.  
<sup>b</sup> Patients who have been prescribed Sogroya<sup>®</sup> for an FDA-approved indication and who have commercial insurance may be eligible to receive a limited supply of free product from JumpStart<sup>TM</sup>. 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<sup>TM</sup> 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 #: \_\_\_\_\_

<sup>1</sup>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<sup>®</sup> (somapacitan-beco) injection? (required) \***

Growth Hormone Deficiency (GHD):  E23.0 - Hypopituitarism  E23.1 - Drug-induced hypopituitarism  E89.3 - Postprocedural hypopituitarism  
 Idiopathic Short Stature (ISS):  R62.52 - Short stature (child)  P05.10 - Newborn born small for gestational age  
 Noonan Syndrome:  Q87.1 - Congenital malformation syndromes predominantly associated with short stature

Small for Gestational Age (SGA):  P05.10 - Newborn born small for gestational age

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

**PRESCRIPTION**

**If requesting JumpStart<sup>TM</sup>, please select both Prescription fields (required) \***  JumpStart<sup>TM</sup> Prescription  Ongoing Prescription

Sogroya<sup>®</sup> (somapacitan-beco) prefilled pen:  5mg  10mg  15mg  
 NovoFine<sup>®</sup> Needles:  32G Tip (6mm) disposable needles  Autocover<sup>®</sup> 30G (8mm) disposable safety needles  
 PenMate<sup>®</sup> 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<sup>®</sup>, 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<sup>®</sup>") 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<sup>®</sup>. I give you permission to contact me, or the above named patient/Caregiver, with any questions related to NovoCare<sup>®</sup>.

**Prescriber signature (no signature stamps): \*** \_\_\_\_\_ **Date: \*** \_\_\_\_/\_\_\_\_/\_\_\_\_