Patient Enrollment Form | Rare Blood Disorders

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

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

Select a product: ☐ Alhemo® ☐ NovoSeven® RT ☐ Novoeight® ☐ Rebinyn® ☐ Esperoct® ☐ Tretten®

Access Support Requested:

☐ Prior Authorization/Reauthorization support request

If PA approved, provide PA approval number_____ with dates from:_____ to:_____.

☐ Appeals support request

Additional Services (may vary by product):

☐ Trial Program[a] 30 day free trial product

☐ Patient has commercial prescription coverage, such as an HMO or PPO

☐ Patient is naive to product requested

☐ JumpStart™[a] new patients with a delay in commercial coverage decision

☐ Interim[a] existing patients with a gap in commercial coverage

☐ NovoCare® Savings Offer (if eligible) For complete copay terms and conditions, visit RBDsavings.com

☐ Alhemo® Device Training: ☐ In-person ☐ Virtual

[a] Patients who have been prescribed one of the above products for an FDA-approved indication and who have commercial insurance may be eligible to receive a limited supply of free product from Trial and/or 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. Trial and JumpStart™ products are 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 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:***
Email:			**Primary phone:***
Primary guardian/caregiver (required if patient under 18 years old):*			Relationship to patient:
Primary pharmacy insurance: (Please attach a copy of the insurance card if available)			Phone:
Insurance subscriber name:			DOB (MM/DD/YYYY):
Rx # ID:	Rx Group #:	Rx PCN #:	Rx BIN #:
Primary medical insurance: (Please attach a copy of the insurance card, including front & back, if available)			Phone:
Subscriber name:	Subscriber ID:	Policy/group #:	
Secondary medical insurance:			Phone:
Subscriber name:	Subscriber ID:	Policy/group #:	

† 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 a Novo Nordisk factor product? *(required)* *

☐ D66 - Congenital Hemophilia A (Factor VIII deficiency) without inhibitors

☐ D66 - Congenital Hemophilia A (Factor VIII deficiency) with inhibitors

☐ D67 - Congenital Hemophilia B (Factor IX deficiency) without inhibitors

☐ D67 - Congenital Hemophilia B (Factor IX deficiency) with inhibitors

☐ D68.2 - Other congenital factor deficiency (FVII)

☐ D68.2 - Other congenital factor deficiency (FXIII)

☐ D68.311 - Acquired hemophilia

☐ D69.1 - Qualitative platelet defect (Glanzmann's Thrombasthenia)

Other diagnosis:

ICD-10 code and description:_____

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* Indicates a required field

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

ALHEMO® PRESCRIPTION

Prescription Request: *(required)* * Select all that apply ☐ JumpStart™ or Interim Prescription ☐ Ongoing (Commercial) Prescription

Order Information: Complete prescription information. Please fill out all applicable sections or submit a prescription with this enrollment form.

Patient Weight:* _____ kg	Alhemo® (Concizumab) Multi-use pre-filled pen formulation. Please specify quantity of pens.	Directions:	Refills:
Loading Dose	_____60 mg/1.5 mL _____150 mg/1.5 mL _____ 300 mg/3 mL		
Initial Maintenance Dose			
Final Maintenance Dose			
NovoFine® Plus Needles: 32G Tip (4mm) disposable needles	_____ boxes of 100	Use as Directed	Refills: _____

Dosing highlights of prescribing information on following pages. For full prescribing information, see product specific package insert.

NOVOSEVEN® RT, NOVOEIGHT®, REBINYN®, ESPEROCT®, TRETTEN® PRESCRIPTION

Prescription Request: *(required)* * Select all that apply ☐ JumpStart™ / Trial / or Interim Prescription ☐ Ongoing (Commercial) Prescription

Patient Weight:* _____ kg IV Access: ☐ PIV/butterfly ☐ Implanted Port ☐ PICC ☐ Central Line

Order Information: Complete prescription information below or submit a prescription with the strengths and assay limits. Quantity limits apply.

Product name:	Dose:	Directions:	Qty:	Refills:

Dosing highlights of prescribing information on following pages. For full prescribing information, see product specific package insert.

SPECIALTY PHARMACY

Prescription to be sent to Specialty Pharmacy by: ☐ Healthcare Provider ☐ NovoCare®	Ship drug to: ☐ Patient's home ☐ Prescribing HCP		
Preferred Specialty Pharmacy:	Specialty Pharmacy phone:	Specialty Pharmacy fax:	
Specialty Pharmacy address:	City:	State:	Zip:

PRESCRIBER AUTHORIZATION

Prescriber name:*	**License #:***
Practice name and 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) in my medical judgment, I have determined that the product(s) being prescribed which are detailed on the accompanying prescribing information (and listed only with those on label indications, appropriate treatment type, approved patient population, labeled dosing, and frequency) 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. 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 with any questions related to NovoCare®. I authorize my contact information to be shared with Novo Nordisk field representatives for the sole purpose of providing ongoing educational information about Alhemo®.

Prescriber signature (no signature stamps):*	**Date:***

RARE BLOOD DISORDERS | HIGHLIGHTS OF PRESCRIBING INFORMATION

Alhemo®: Hemophilia A (Factor VIII deficiency) with FVIII inhibitors and Hemophilia B (Factor IX deficiency) with FIX inhibitors

Treatment type	Patient Population/Bleed type	Dose/Target factor level	Frequency

Prophylaxis	Adult (≥ 12 yrs)	Recommended dosing regimen:
		• Day 1: Loading dose of 1 mg/kg
		• Day 2: Once-daily dose of 0.20 mg/kg until individualization of maintenance dose (see below)
		  o 4 weeks after initiation of treatment: For dose optimization measure concizumab mci plasma concentration by Concizumab Enzyme-Linked Immunosorbent Assay (ELISA) prior to administration of next scheduled dose
		• After concizumab mtci plasma concentration result is available but recommended no later than 8 weeks after initiation of treatment: Individualize maintenance dose of Alhemo® based on the following concizumab mici plasma concentrations:
		  o <200 ng/mL: adjust to a once-daily dose of 0.25 mg/kg
		  o 200 to 4000 ng/mL: continue once-daily dose of 0.20 mg/kg
		  o >4000 ng/mL: adjust to a once-daily dose of 0.15 mg/kg
			Daily

Novoeight®: Hemophilia A (congenital FVIII deficiency)

Treatment type	Patient Population/Bleed type	Dose/Target factor level	Frequency
Prophylaxis	Adult (≥ 12 yrs)	20-50 IU/kg	3 times weekly
	Adult (≥ 12 yrs)	20-40 IU/kg	Every other day
	Pediatric	25-60 IU/kg	3 times weekly
	Pediatric	25-50 IU/kg	Every other day
On-demand	Minor bleed	20-40 IU/dL	Every 12-24 hours
	Moderate bleed	30-60 IU/dL	Every 12-24 hours
	Major bleed	60-100 IU/dL	Every 8-24 hours
Perioperative	Minor surgery	30-60 IU/dL	Every 24 hours
	Major surgery	80-100 IU/dL	Every 8-24 hours

Esperoct®: Hemophilia A (congenital FVIII deficiency)

Treatment type	Patient Population/Bleed type	Dose	Frequency
Prophylaxis	Adult (≥ 12 yrs)	50 IU/kg	Every 4 days*
	Pediatric (< 12 years)	65 IU/kg	2 times weekly*
On-demand	Adult: Minor bleed	40 IU/kg	1 dose should be sufficient
	Adult: Moderate bleed	40 IU/kg	An additional dose may be administered after 24 hours
	Adult: Major bleed	50 IU/kg	Additional dose(s) may be administered approximately every 24 hours
	Pediatric: any bleed	65 IU/kg	Minor: 1 dose should be sufficient
			Moderate: An additional dose may be administered after 24 hours
			Major: Additional dose(s) may be administered approximately every 24 hours
Perioperative	Adult: Minor or Major	50 IU/kg	Minor: Every 24 hours
			Major: Every 24 hours for the first week, then approximately every 48 hours until wound healing has occurred
	Pediatric: Minor or Major	65 IU/kg	Minor: Every 24 hours
			Major: Every 24 hours for the first week, then approximately every 48 hours until wound healing has occurred

*Frequency can be adjusted based on bleeding episodes

Rebinyn®: Hemophilia B (congenital FIX deficiency); All doses/frequencies are for both adult and pediatric populations

Treatment type	Patient Population/Bleed type	Dose	Frequency
Prophylaxis	N/A	40 IU/kg	Once weekly*
On-demand	Minor/Moderate bleed	40 IU/kg	1 dose should be sufficient, but additional doses of 40 IU/kg can be given
	Major bleed	80 IU/kg	Additional doses of 40 IU/kg can be given
Perioperative	Minor surgery	40 IU/kg	1 pre-op dose should be sufficient, additional doses of 40 IU/kg can be given
	Major surgery	80 IU/kg	Pre-op dose; additional doses of 40 IU/kg can be given every 1-3 days within 1st week
*Frequency can be adjusted based on bleeding episodes and physical activity			

Tretten®: Congenital FXIII A-subunit deficiency; adult and pediatric populations

Treatment type	Patient Population/Bleed type	Dose	Frequency
Prophylaxis	N/A	35 IU/kg	Monthly*
*Consider dose adjustment if adequate coverage is not achieved			

NovoSeven® RT

Indication	Treatment type	Patient Population/Bleed type	Dose	Frequency
Hemophilia A with inhibitors or hemophilia B with inhibitors	On-demand	Adult/pediatric: all other bleeds	90 mcg/kg	Every 2 hours until hemostasis is achieved, or until the treatment has been judged to be inadequate
		Adult/pediatric: severe bleeds	90 mcg/kg	Every 2 hours until hemostasis and then post hemostatic every 3-6 hours
	Perioperative	Adult/pediatric: minor surgery	90 mcg/kg	Immediately before surgery, every 2 hours during surgery, every 2 hours after surgery for 48 hours and then every 2-6 hours until healing occurs
		Adult/pediatric: major surgery	90 mcg/kg	Immediately before surgery, every 2 hours during surgery, every 2 hours after surgery for 5 days and then every 4 hours or by continuous infusion (50 mcg/kg/hr) until healing occurs
Congenital FVII deficiency	On-demand	Adult/pediatric	15-30 mcg/kg	Every 4-6 hours until hemostasis achieved
	Perioperative	Adult/pediatric	15-30 mcg/kg	Immediately before surgery, every 4-6 hours during surgery and until healing occurs
Glanzmann's thrombasthenia (with refractoriness to platelet transfusions)	On-demand	Adult/pediatric	90 mcg/kg	Every 2-6 hours until hemostasis achieved
	Perioperative	Adult/pediatric	90 mcg/kg	Immediately before surgery, every 2 hours during surgery and every 2-6 hours post surgery
Acquired hemophilia	On-demand	Adult	70-90 mcg/kg	Every 2-3 hours until hemostasis achieved
	Perioperative	Adult	70-90 mcg/kg	Immediately before surgery, every 2-3 hours during surgery and until hemostasis achieved