norditropin®
(somatropin) injection
5 mg, 10 mg, 15 mg, 30 mg pens

# Patient Enrollment Form | Pediatric

Phone: 1-888-668-6444
Fax: 1-888-508-8200

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

**Access Support Requested:**

☐ Prior Authorization support request. If PA approved, provide PA approval number _____ with dates from: _____ to: _____.
☐ Appeals support request

**Additional Services:**

☐ JumpStart™[ab] request
☐ Norditropin® FlexPro® Device Training: ☐ In-person ☐ Virtual
☐ Starter Kit
☐ NovoCare® Savings Offer (if eligible). For complete terms and conditions, visit norditropinsavings.com.

[a] Terms and conditions of JumpStart™ require active, timely prescriber support of Prior Authorization and/or Appeal documentation submission.

[b] Patients who have been prescribed Norditropin® for an FDA-approved indication and who have commercial insurance may be eligible to receive a limited supply of free product from 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. JumpStart™ 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: | |
| Shipping address 1 (No P.O. box): | Shipping address 2: | |
| City: | State: | **Zip:*** |
| Email: | Primary phone: | |
| **Primary guardian/caregiver:*** | DOB (MM/DD/YYYY): | Relationship to patient: |
| **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

**If requesting JumpStart™ please select both Prescription fields *(required)**** ☐ **JumpStart™ Prescription** ☐ **Ongoing Prescription**

Norditropin® (somatropin) FlexPro® prefilled pen:
☐ 5mg ☐ 10mg ☐ 15mg ☐ 30mg

NovoFine® Needles:
☐ 32G Tip (6mm) disposable needles
☐ Autocover® 30G (8mm) disposable safety needles

☐ PenMate® reusable cover for needles: ☐ 1 ☐ 2

Directions:
Inject _____ mg SC daily _____ days per week _____ 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: _____ | 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:*** |