Patient Enrollment Form | Obesity

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

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

novo nordisk® | NovoCare®
Savings | Coverage | Support

* Indicates a required field

SERVICES REQUESTED

Select one or both products and request type:* ☐ Wegovy® (semaglutide) injection 2.4 mg ☐ Saxenda® (liraglutide) injection 3 mg ☐ Both

☐ **QuickCheck™** (Benefit investigation coverage details returned in about 4 business hours)

☐ **Full NovoCare® program enrollment** (Benefit investigation, prior authorization or appeal coordination, patient outreach and Savings Offer enrollment. 24 business hour turnaround)

PATIENT/INSURANCE INFORMATION

Patient first name:*	**Patient last name:***	DOB (MM/DD/YYYY):*
Gender†:* ☐ Male ☐ Female	Preferred language: ☐ English ☐ Spanish ☐ 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 2.4 mg

☐ 0.25 mg/0.5 mL ☐ 0.5 mg/0.5 mL ☐ 1.0 mg/0.5 mL ☐ 1.7 mg/0.75 mL ☐ 2.4 mg/0.75 mL

Days supply: ☐ 28 ☐ 56 ☐ 84 ☐ Other: _____

Saxenda® (liraglutide) injection 3 mg

Days supply: ☐ 30 ☐ 60 ☐ 90 ☐ Other: _____

What is the primary diagnosis for which you are prescribing Wegovy® or Saxenda®?

Common obesity codes:

- ☐ E66.0 - Obesity due to excess calories
  - ☐ E66.01 - Morbid obesity due to excess calories
  - ☐ E66.09 - Other obesity due to excess calories
- ☐ E66.1 - Drug-induced obesity
- ☐ E66.2 - Morbid obesity with alveolar hypoventilation
- ☐ E66.3 - Overweight
- ☐ E66.8 - Other obesity
- ☐ E66.9 - Obesity, unspecified (can be used 1x for initial visit only)

BMI codes:

- ☐ Z68. _____ - Please write in first two digits of BMI value between 30.0 and 39.9
- ☐ Z68.41 - BMI 40.0-44.9
- ☐ Z68.42 - BMI 45.0-49.9
- ☐ Z68.43 - BMI 50.0-59.9
- ☐ Z68.44 - BMI 60.0-69.9
- ☐ Z68.45 - BMI 70.0 or greater
- ☐ 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? ☐ Initiation ☐ Continuation ☐ Restart	Height (cm):	Inital weight (kg):	Inital BMI:

Does the patient have a weight-related comorbid condition? ☐ Dyslipidemia ☐ Hypertension ☐ Type 2 Diabetes ☐ Cardiovascular Disease ☐ Other:

Has patient previously received prescription weight management medication? ☐ Yes ☐ No

☐ phentermine ☐ Belviq® (lorcaserin) ☐ Contrave® (naltrexone/bupropion ER) ☐ Qsymia® (phentermine-topiramate ER) ☐ Xenical®/Alli® (orlistat) ☐ Tenuate® (diethylpropion)
☐ Didrex® (bensphetamine) ☐ Other (please specify): _____

Start date of weight management medication (MM/DD/YYYY):	Failed date of weight management medication (MM/DD/YYYY):
Is the patient unable to take stimulant weight loss medication? ☐ Yes ☐ No	Has the patient failed to lose 1lb/week through lifestyle modificaiton? ☐ Yes ☐ No

Document lifestyle modification, (if applicable): ☐ Caloric restriction ☐ Exercise ☐ Other (please specify): _____

Length: ☐ 3 months ☐ 6 months ☐ 6-12 months ☐ ≥ 12 months

Patient will make a continued attempt at weight loss plan while on obesity therapy (exercise, reduced calorie) ☐ Yes ☐ No

Complete only for pediatric patients aged 12 years and older

Wegovy® only: Is the patient's initial BMI at the 95 percentile or greater for age and sex: ☐ Yes ☐ No

Saxenda® only: Does the patient's initial BMI correspond to 30 kg/m^2 or greater for adults (obese) by international cut-offs (Cole Criteria)? ☐ Yes ☐ No

HEALTH CARE PROVIDER AUTHORIZATION

Prescriber name:*			State license #:*
Practice name:	Office contact:		Preferred method of contact: ☐ Phone ☐ Fax ☐ 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:*