QuickCheck™ | 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

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:		Ship drug to: ☐ Patient's home ☐ Prescribing HCP
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:
Rx # ID:	Rx Group #:	Rx PCN #:	Rx BIN #:
Secondary pharmacy insurance: (Please attach a copy of the insurance card if available)			Phone:
Rx # ID:	Rx Group #:	Rx PCN #:	Rx BIN #:
Employer name:		Employer 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 (without inhibitors)
☐ D66 - Congenital hemophilia A (with inhibitors)
☐ D67 - Congenital hemophilia B (without inhibitors)
☐ D67 - Congenital hemophilia B (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: _____

PRODUCT

Select Product:

☐ NovoSeven® RT
☐ 1 mg ☐ 2 mg ☐ 5 mg ☐ 8 mg

☐ Novoeight®
☐ 250 IU ☐ 500 IU ☐ 1000 IU ☐ 1500 IU ☐ 2000 IU ☐ 3000 IU

☐ Tretten®
☐ 2500 IU

☐ Rebinyn®
☐ 500 IU ☐ 1000 IU ☐ 2000 IU ☐ 3000 IU

☐ Esperoct®
☐ 500 IU ☐ 1000 IU ☐ 1500 IU ☐ 2000 IU ☐ 3000 IU

Product name:	Dose:	Directions:	Qty:

Do you intend to buy and bill? ☐ Yes ☐ No

PRESCRIBER AUTHORIZATION

Prescriber name:*		Preferred method of contact: ☐ Phone ☐ Fax ☐ Email	
Practice name and office contact:			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 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. 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®.

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