

Statement of Medical Necessity

Phone: 888-NOVO-444
Fax: 888-508-8200

nordicare[®]
Comprehensive Support Services

- New start Continuing treatment Restarting treatment

ADULT PATIENT

Patient name: _____ DOB: _____ Patient SSN: _____
Address: _____
City: _____ State/zip: _____
Home phone: _____ Work phone: _____ Cell phone: _____
 Male Female

PATIENT AUTHORIZATION

Patient release: I understand that Novo Nordisk, its personnel, and/or agents including RxCrossroads, LLC (collectively, NordiCare[®]) must use, share, and store my personal health information in order to help me gain reimbursement coverage for and begin Norditropin[®] therapy (including, if requested, product demonstration by a NordiCare[®] representative). I hereby authorize NordiCare[®] to contact my healthcare provider, insurance company, or other third-party payers, and for such parties to give NordiCare[®] all necessary medical records and payer information. This authorization expires on December 31, 2020, unless I notify both my healthcare provider and NordiCare[®] (at fax number 888-508-8200) in writing that I withdraw my approval to share my health information. I understand that once my health information is released to NordiCare[®], it is no longer protected by federal law but that NordiCare[®] will protect such information and use it only for the purposes stated above.

Signature of patient _____ Date _____
 Please check here if you would like to receive future offers and communications from Novo Nordisk. Please provide your e-mail address: _____

INSURANCE

Primary insurance: _____ **Secondary insurance:** _____
Phone: _____ Phone: _____
Subscriber name: _____ Subscriber name: _____
Subscriber ID #: _____ Subscriber ID #: _____
Policy/group #: _____ Policy/group #: _____
Attach copy of both sides of patient's insurance card(s). Drug discount: _____

DIAGNOSIS

What is the primary diagnosis for which you are prescribing Norditropin[®]?
 Adult GHD:
 Childhood onset - due to - **Isolated GHD/pituitary dwarfism (253.3)**
 Adult onset **Panhypopituitarism (253.2)** - or - **Other FDA-approved diagnosis:** _____
 Iatrogenic hypopituitarism (253.7) **ICD-9 code:** _____

MEDICAL ASSESSMENT

Attach (if applicable): Stim test date: _____ Agent #1: _____ Peak value: _____ Units: _____
 Patient's growth chart Stim test date: _____ Agent #2: _____ Peak value: _____ Units: _____
 Clinical notes/history Date: _____ Height: _____ (cm) _____ % Weight: _____ (kg) _____ %
 Test results (Stim test and labs: x-ray, MRI, IGF-1, IGFBP3) Date: _____ IGF-1: _____ SDS: _____ IGFBP3: _____

PRESCRIPTION

Physician name: _____ License #: _____ DEA #: _____ Tax ID #: _____
Practice name (office contact): _____ Address: _____
City: _____ State/zip: _____ Phone: _____ Fax: _____ E-mail: _____

- Register patient with NordiCare[®] only (no insurance verification or training needed).
 Ship Starter Kit: Appropriate kit will be sent for prescribed delivery system, disposable needles, and allied injection materials. Spanish material
 JumpStart[™] request (if qualified) should be received by _____ (date). Shipping schedule to be confirmed with patient by NordiCare[®].
 Initiate insurance verification by NordiCare[®].
 Initiate training by NordiCare[®]: Home Clinic

- Norditropin NordiFlex[®]:** (disposable pen device)
 5 mg/1.5 mL (NDC 0169-7704-11)
 10 mg/1.5 mL (NDC 0169-7705-11)
 15 mg/1.5 mL (NDC 0169-7708-11)
 NordiFlex PenMate[®] accessory
- Norditropin[®] cartridge:** (reusable pen device)
 5 mg/1.5 mL cartridge with NordiPen[®] 5 delivery system (NDC 0169-7768-11)
 15 mg/1.5 mL cartridge with NordiPen[®] 15 delivery system (NDC 0169-7770-11)
 NordiPenMate[®] accessory
- NovoFine[®] needles*:**
 31 G (6 mm) disposable needles _____ box(es) of 100 (NDC 0169-1852-55)
 30 G (8 mm) disposable needles _____ box(es) of 100 (NDC 0169-1852-50)
 30 G (8 mm) Autocover[®] disposable safety needles _____ box(es) of 100 (NDC 0169-1852-75)

DOSE

Daily dose: _____ mg/day
Dose frequency: _____ sc injections/week
Refills: 1 mo 3 mo 6 mo _____

Please remember to indicate the quantity and type (31 G or 30 G) of needles that should be shipped to the patient.

PHYSICIAN AUTHORIZATION

Physician release: I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required for Novo Nordisk, its employees or agents, including RxCrossroads, LLC (collectively, "NordiCare[®]"), to assist in obtaining coverage for Novo Nordisk human growth hormone products and to assist in initiating or continuing Novo Nordisk therapy. I appoint NordiCare[®], on my behalf, to convey this prescription to the dispensing pharmacy.

Physician signature (dispense as written, no signature stamps) _____ NPI # _____ Date _____



*Needles may require a prescription in some states.

For faster processing, did you remember to?

- Have your patient sign the form (see "Patient Authorization")
- Attach a copy of both sides of patient's insurance card(s)
- Indicate which FDA-approved diagnosis applies to this patient (see "Diagnosis")
- Select the type and amount of NovoFine® needles* (see "Prescription")
- Select the number of refills (see "Dose")
- Fax the reverse side



Norditropin NordiFlex®
5 mg/1.5 mL



Norditropin NordiFlex®
10 mg/1.5 mL



Norditropin NordiFlex®
15 mg/1.5 mL



NordiFlex PenMate®



NordiPen®
5 mg/1.5 mL



NordiPen®
15 mg/1.5 mL



NordiPenMate®

*Needles may require a prescription in some states.

Please see Important Safety Information on back cover.

Please see Prescribing Information on reverse side of cover.

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