QuickCheck™

Novo Nordisk Hemophilia/RBD benefits verification in ~4 hours

NovoCare®

Phone: 1-844-NOVO-SEC
(1-844-668-6732)
Fax: 1-866-488-6576

PATIENT INFORMATION

First name: | Last name: | Birth date:

Street address: | City, State: | Zip:

PRIMARY INSURANCE INFORMATION

Please attach copies of both insurance cards and provide insurance information below. ***(required)***

Medical insurance company: | Member ID: | Group ID:

Cardholder name: | | Relationship to cardholder:

Insurance phone: ( ) (if available) | Bin #: (if available)

Medical group (IPA):

Pharmacy benefit plan: | Member ID: | Group ID:

Insurance phone: ( ) (if available) | Bin #: (if available)

Person code #: | PCN:

Employer name: | **Employer group #:**

DIAGNOSIS

What is the primary diagnosis for which you are prescribing a Novo Nordisk factor product? ***(required)***

- ☐ 286.0 (D66) Congenital hemophilia A (without inhibitors)
- ☐ 286.0 (D66) Congenital hemophilia A (with inhibitors)
- ☐ 286.1 (D67) Congenital hemophilia B (without inhibitors)
- ☐ 286.1 (D67) Congenital hemophilia B (with inhibitors)
- ☐ 286.2 (D68.2) Other congenital factor deficiency (FVII)
- ☐ 286.2 (D68.2) Other congenital factor deficiency (FXIII)
- ☐ 286.52 (D68.311) Acquired hemophilia
- ☐ 287.1 (D69.1) Qualitative platelet defect (Glanzmann's Thrombasthenia)

PRODUCT TO CHECK/DOSING

Product name	**Dose**	**Infusion instructions**	**Quantity to dispense**

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

PHYSICIAN INFORMATION AND 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 or guardian'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, "NovoCare®"), to assist in obtaining initial review of benefit coverage for specified Novo Nordisk factor product and to assist in initiating Novo Nordisk therapy.

Health care professional signature | **Date** | **NPI #** | **Tax ID #**

Health care professional name (please print) | **Name of treatment center** (if applicable) | ( )

Address | **City, State** | **Phone number** ( )

Preferred mode of contact ☐ **Email** ☐ **Fax number**

Nurse or office contact name

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