**Phone: 1-888-NOVO-444 (1-888-668-6444) Fax: 1-888-508-8200**

novo nordisk®

**NovoCare®**
Patient Affordability and Access Support

# QuickCheck™

**Norditropin® (somatropin) injection benefits verification in ~4 hours**

*= required field*

## PATIENT INFORMATION

First name _____ Last name _____ Birth date ____ /____ /____

Street address _____ City, State _____ Zip _____

## PRIMARY INSURANCE INFORMATION

**Please attach copies of both insurance cards *or* provide insurance information below.**

**Primary insurance holder name** _____ Phone # ( )

**Medical insurance company** _____ Member ID _____ Group ID _____

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 Norditropin®? (*required*)**

**Adult Growth Hormone Deficiency (GHD):**

- ❑ E23.0-Hypopituitarism
- ❑ E23.1-Drug-induced hypopituitarism or E89.3-Postprocedural hypopituitarism

**Pediatric GHD:**

- ❑ E23.0-Hypopituitarism
- ❑ E23.1-Drug-induced hypopituitarism or E89.3-Postprocedural hypopituitarism

**Small for Gestational Age (SGA):**

- ❑ R62.52-Short stature/growth failure

**PLUS**

- ❑ P05.9-Newborn affected by slow intrauterine growth
- ❑ P05.10-Newborn small for gestational age, unspecified weight

**Idiopathic Short Stature:**

- ❑ R62.52-Short stature (child)

**Turner Syndrome:**

- ❑ Q96.9-Turner's syndrome, unspecified

**Noonan Syndrome:**

- ❑ Q87.89-Other specified congenital malformation syndromes, not elsewhere classified or Q89.8-Other specified congenital malformations or Q87.1-Congenital malformation syndromes predominantly associated with short stature

**Prader-Willi Syndrome:**

- ❑ Q87.89-Other specified congenital malformation syndromes, not elsewhere classified or Q89.8-Other specified congenital malformations or Q87.1-Congenital malformation syndromes predominantly associated with short stature

**Other diagnosis:**

ICD-10 code and description: _____

## PRODUCT TO CHECK/DOSING

**Norditropin® FlexPro® (*required*)**

- ❑ 5 mg/1.5 mL (NDC 0169-7704-21)
- ❑ 10 mg/1.5 mL (NDC 0169-7705-21)
- ❑ 15 mg/1.5 mL (NDC 0169-7708-21)
- ❑ 30 mg/3 mL (NDC 0169-7703-21)

**Dosing:**

Daily dose _____ mg/day

## PHYSICIAN INFORMATION AND RELEASE

**Physician release:** By signing this QuickCheck™ Form, I hereby certify the following: (a) I am a licensed practitioner in good standing under state law; (b) the above therapy is medically necessary; and (c) the information I have provided on this QuickCheck™ Form is, to the best of my knowledge, true, complete, and accurate in all respects.

I further certify that, pursuant to the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 ("HIPAA"), I have obtained prior express authorization from the above named patient, or where appropriate the patient's Legal Guardian, in the form of a written consent or express waiver that is legally sufficient under HIPAA, which permits the use or disclosure of the above named patient's above protected health information ("PHI") or other limited, but necessary, information, to Novo Nordisk Inc., its employees, or partners, including RxCrossroads, LLC (collectively, "NovoCare®"), for the sole purpose of providing assistance in obtaining coverage for Novo Nordisk human growth hormone products, as well as assistance in initiating or continuing therapy. I further agree that I will immediately notify NovoCare® if the above named patient, or where appropriate the patient's Legal Guardian, revokes their consent to share their PHI with NovoCare®.

Accordingly, I appoint NovoCare®, on my behalf, to convey this prescription to the dispensing pharmacy.

**Health care professional signature** **Date** [MM/DD/YY] **NPI #** **Tax ID #** ( )

**Health care professional name** (please print) **City, State** **Phone number** ( )

**Preferred mode of contact:** ❑ **Email** ❑ **Fax number**

**Nurse or office contact name**

**Office name**