NovoCare® Patient Affordability and Access Support

Saxenda® (liraglutide) injection 3mg
Statement of Medical Necessity
Program Phone: 1-888-809-3942

Please click here for Saxenda® Prescribing Information, including Boxed Warning.

1. REQUEST TYPE AND INSTRUCTIONS

Select requested service:

☐ QuickCheck™: Cost and coverage information in ~4 hours

☐ Benefit Investigation: Cost and coverage information communicated to you and your patient plus additional patient support. Additional support may include PA/appeal assistance and enrollment into copay/weight management programs for eligible patients.

Complete the required sections and fax the form to 844-667-3475.

2. PATIENT INFORMATION (Please print)

Patient Name: _____ Date of Birth: _____ Gender: M ____ F ____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

3. PRESCRIPTION INSURANCE INFORMATION (Please provide a copy of front and back of patient's prescription insurance card or fill out section below)

PRIMARY PRESCRIPTION COVERAGE		SECONDARY PRESCRIPTION COVERAGE (If applicable)	
Insurance Name:		Insurance Name:	
Insurance Phone #:		Insurance Phone #:	
Member ID #:		Member ID #:	
Employer:		Employer:	

4. DIAGNOSIS AND CLINICAL INFORMATION (Not required for QuickCheck™ requests)

Is this request for initiation or continuation of therapy? ☐ Initiation ☐ Continuation

Saxenda® (liraglutide) injection 3 mg (NDC: 0169-2800-15): Dose: _____ Frequency: _____ Quantity: _____ day(s) supply

Primary Diagnosis Code: ☐ E66.9 ☐ E66.01 ☐ E66.09 ☐ R63.5 ☐ E66.3 ☐ Other (please specify): _____

Current patient weight: _____ Height: _____ Current patient BMI: _____

Does the patient have a comorbid condition? ☐ Dyslipidemia ☐ Hypertension ☐ Type 2 Diabetes Other _____

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

☐ Adipex-P® (Phentermine) ☐ Belviq® (Lorcaserin) ☐ Contrave® (Bupropion) ☐ Qsymia® (Phentermine-topiramate) ☐ Xenical®/Alli® (Orlistat)

☐ Tenuate® (Diethylpropion) ☐ Didrex® (Bensphetamine) ☐ Other (please specify): _____

Start date of weight management medication: _____ Failed date of weight management medication: _____

Is the patient unable to take stimulant weight loss medication? ☐ Yes ☐ No

Does patient currently have any of the following: ☐ Concurrent use of other weight-loss products ☐ Pregnancy

If this request is for a refill prescription, the % of patient weight loss within past 16 weeks: _____

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

5. PRESCRIBER/FACILITY INFORMATION (Please ensure all ID#s correspond to the PRESCRIBER)

Prescriber Name: _____

NPI #: _____ License #: _____

Facility Name: _____ Tax ID: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Office Contact: _____

Preferred method of contact: ☐ Email: _____ ☐ Fax: _____

PRESCRIBER CERTIFICATION

My signature certifies that I am a licensed practitioner under state law, that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I further acknowledge that I have obtained the patient's authorization to release the above information as required by applicable privacy laws, including but not limited to, the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. § 1320 et seq., as well as such other information that may be required for RxCrossroads, LLC, acting on behalf of Novo Nordisk Inc. (collectively, "NovoCare® for Saxenda®"), to assist in obtaining co-pay/coverage information, coverage for Saxenda®, and to assist in initiating or continuing therapy.

If your patient's plan requires a prior authorization (PA) or accepts appeals, do you authorize NovoCare® for Saxenda® to use the information provided on this form to complete and submit the PA or appeal on behalf of the patient? If you select, "Yes," you must complete section 4 and select the "Benefit Investigation" option in section 1. ☐ Yes ☐ No

Prescriber's Signature: _____ **Date:** _____