Return via:
Mail: NovoCare®, Attn: Patient Auth Department, PO Box 18648, Louisville, KY 40261-9907
Fax: 1-888-508-8200 **Email:** help@NovoCare.com **Online:** Register at www.NovoCare.com

novo nordisk®

NovoCare®
Patient Affordability and Access Support

Patient authorization for NovoCare® Patient Assistance Program

Patient authorization and signature

I, the patient, understand that RxCrossroads, LLC, acting on behalf of Novo Nordisk Inc. (collectively, NovoCare®), must use, share, and store my protected health information (PHI) in order to provide NovoCare® support. I hereby authorize NovoCare® to contact my health care provider, pharmacy, insurance company, or other third-party payers, and for such parties to give NovoCare® all necessary medical records and payer information, including my growth chart, medical history, clinical notes, test results, prescription drug information, and insurance information. I understand that a copy of this authorization will be provided to anyone disclosing information to NovoCare® so that it may be kept with my records. This authorization expires once I have notified NovoCare® that I have completed my growth hormone treatment (unless a shorter time period is required by state law), or unless I notify both my health care provider and NovoCare® (at fax number **1-888-508-8200**) in writing that I withdraw my approval to share my health information. My withdrawal of approval will not affect any disclosure of PHI made prior to my withdrawal.

I understand that once my health information is released to NovoCare®, it may no longer be protected by state and federal law but that NovoCare® will protect such information and use it only for the purposes stated above. I understand that NovoCare® may share my PHI with other parties in order to administer the program. I understand that I have a right to receive a copy of this authorization.

I understand that I do not have to sign the authorization form. If I choose not to sign it, my ability to obtain treatment and my eligibility for benefits under my health plan will not be affected. However, if I do not sign the authorization form, NovoCare® may not be able to provide reimbursement help or find out if I am eligible for any other NovoCare® support.

Print patient's name _____ **Print legal representative's name** _____

Signature of patient _____ **OR** **Signature of legal representative** _____ **Date** _____

I agree that the information I am providing may be used by Novo Nordisk, its affiliates, or vendors to keep me informed about new products, services, special offers, or other opportunities that may be of interest to me, as they become available. THESE COMMUNICATIONS MAY CONTAIN MATERIAL MARKETING OR ADVERTISING NOVO NORDISK PRODUCTS, GOODS, OR SERVICES. Novo Nordisk will take appropriate measures to protect my information. I can stop Novo Nordisk from sending me future communications by calling **1-877-744-2579**, sending a brief note with my name and address to Novo Nordisk at 800 Scudders Mill Road, Plainsboro, NJ 08536, or by clicking on the "unsubscribe" link in future email communications. By providing my information to Novo Nordisk and acknowledging below, I certify that I am at least eighteen (18) years of age.

Print patient's name _____ **Print legal representative's name** _____

Signature of patient _____ **OR** **Signature of legal representative** _____ **Date** _____

For more information about NovoCare® call **1-888-NOVO-444** (1-888-668-6444), between 8:00 AM and 8:00 PM ET, Monday through Friday, and visit **www.NovoCare.com**.