VAGIFEM® 10 mcg (estradiol vaginal tablets)

Patient Assistance Program Application

Phone: 1-888-868-9852
Fax: 1-888-868-9853

Monday - Friday
8:00 AM to 8:00 PM ET

PO Box 7613
Overland Park, KS 66207

novo nordisk® | NovoCare® Savings | Coverage | Support

* Indicates a required field ☐ New Application ☐ Renewal

APPLICATION INSTRUCTIONS

The **Novo Nordisk Hormone Therapy Patient Assistance Program (PAP)** provides medication to eligible applicants at no charge. If the applicant qualifies under the PAP guidelines, up to a 90-day supply of the requested medication(s) and applicable device(s) will be shipped to the patient. Patients who qualify for PAP will be eligible to receive shipments, as prescribed, for up to 1 year from the approval date.[a]

The Novo Nordisk PAP is free.
There is no registration charge or monthly fee for participating in the Novo Nordisk PAP.[b]

[a] All requests are subject to product availability and patient eligibility verification.
[b] Product is provided at no cost to the patient or the HCP, is not contingent on any product purchase, and the patient and HCP must not: (1) bill any third-party for the product, or (2) resell the free product.

Prescriber to complete ALL required fields, sign and date the application.

PLEASE DO NOT INCLUDE PATIENT MEDICAL RECORDS WITH THIS APPLICATION.

PATIENT INFORMATION

Patient name:*			DOB (MM/DD/YYYY):*
Gender†:* ☐ Male ☐ Female	Preferred language: ☐ English ☐ Spanish ☐ Other:		
Home address (No P.O. box):		City: State:	Zip:*
Shipping address (If different from Home Address):		City: State:	Zip:*
Email:	Primary phone:		Ship drug to: ☐ Patient's home ☐ Prescribing HCP
Annual household adjusted gross income from most recent federal tax return: $			Number of people in household (including patient):
Number of people in household under 18:	Does your patient have any form of prescription drug coverage*? ☐ Yes ☐ No If yes, please check ALL that apply and complete information below.		
Plan Name:	Member ID:		Phone:

☐ Employer-supplied or commercial/private drug coverage
☐ Medicare Part D (prescription drug coverage) (include a copy of the front and back of your card)
☐ Medicare Part B (medical benefit that covers some prescription medications)
☐ VA or Military Benefits
☐ Medicaid Prescription Drug Coverage
☐ Medicare Low Income Subsidy (LIS/Extra Help)

Not sure if you have Medicare Rx coverage? Medicare Part D Plan cards usually have "Medicare Rx" somewhere on the card. Medicare Advantage Plans with prescription coverage also have "Medicare Rx" somewhere on the card.

† Novo Nordisk and its partners recognize that patients may not identify as male or female. However, many insurance companies still require that one of these two fields be used for each of their members. Please indicate the gender on file with the patient's insurance company.

PRESCRIPTION

Therapy Cycle:	Refills:	Product Selection:	Directions:
☐ Initial Therapy (New Start)	Zero refills	☐ Vagifem® 10mcg tab, 18ct box 0169-5176-04	☐ Insert 1 tablet vaginally once daily for 2 weeks, then twice weekly thereafter; Dispense 1-month supply
☐ Continued Therapy (Renewals)		☐ Vagifem® 10mcg tab, 8ct box 0169-5176-03	☐ Insert 1 tablet vaginally twice weekly; Dispense 3-month supply

PRESCRIBER AUTHORIZATION

Prescriber name:*			License #:*	
Practice name and office contact:			Preferred method of contact: ☐ Phone ☐ Fax ☐ Email	
DEA #:	Tax ID #:		NPI #:*	
Phone:*	Fax:*	Email:*		
Address:*	City:*	State:*	Zip:*	

Prescriber release:* My signature certifies that I am a licensed health care practitioner eligible under state law to prescribe, receive, and dispense the requested medication(s) listed on the attached order, shipped from Novo Nordisk, and that I am not prohibited from participating in federally funded health care programs. If I am a Nurse Practitioner, Physician Assistant, Pharmacist, or PharmD, I certify that I am authorized and eligible in the state within which I am currently practicing to prescribe, receive, and dispense these products, and that I have my supervising Physician's approval to do so if required by law.

Note: Prescriber information must match prescriber's signature.

I also certify that in my medical judgement, I have determined that the product(s) I am prescribing to this patient are to treat diagnosis(es) consistent with indication(s) dosing, and appropriate use(s) as described in the product's prescribing information.

I further certify that all information provided in this section is correct.

I agree that medication(s) provided by Novo Nordisk for the patient named in the Patient Information section will be provided by me to such eligible applicant for his or her own use without charge.

I will not otherwise use any of such medications or prescribe, provide or dispense all or any portion thereof for the use of any other person.

I consent that Novo Nordisk may contact me and/or the patient named in the Patient Information section for verification of applicant status and receipt of the indicated medication(s).

I further consent that Novo Nordisk may, at its discretion and with adequate notice, perform an on-site audit/review solely related to Novo Nordisk Patient Assistance Program (PAP) records related to the patient named above on this application.

I understand that I am not eligible to seek reimbursement for any medication dispensed by the Novo Nordisk PAP from any government program or third-party insurer and will not apply any Novo Nordisk PAP medication towards the patient's True-Out-Of-Pocket (TrOOP) costs.

I also understand that eligibility under the PAP is subject to Novo Nordisk's discretion and that Novo Nordisk reserves the right to modify or terminate the PAP at any time.

Finally, I certify that I receive no direct or indirect payments related to the PAP.

By signing below, I acknowledge that I have read and agree to the Prescriber Authorization.

Prescriber signature (no signature stamps):*	Date:*