



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)			
	<input type="checkbox"/> 286.0 (D66) Congenital hemophilia A (without inhibitors) <input type="checkbox"/> 286.0 (D66) Congenital hemophilia A (with inhibitors) <input type="checkbox"/> 286.1 (D67) Congenital hemophilia B (without inhibitors) <input type="checkbox"/> 286.1 (D67) Congenital hemophilia B (with inhibitors)		<input type="checkbox"/> 286.2 (D68.2) Other congenital factor deficiency (FVII) <input type="checkbox"/> 286.2 (D68.2) Other congenital factor deficiency (FXIII) <input type="checkbox"/> 286.52 (D68.311) Acquired hemophilia <input type="checkbox"/> 287.1 (D69.1) Qualitative platelet defect (Glanzmann's Thrombasthenia)	
PRODUCT TO CHECK/DOSING	Product name	Dose	Infusion instructions	Quantity to dispense
	<hr/> <hr/> <hr/> Do you intend to buy and bill? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Email	<input type="checkbox"/> Fax number	
	Nurse or office contact name			

