

* Indicates a required field ☐ New start ☐ Reauthorization ☐ Restarting treatment ☐ Transitioning from: _____

SERVICES REQUESTED	Access Support Requested: ☐ Prior Authorization/Reauthorization support request If PA approved, provide PA approval number _____ with dates from: _____ to: _____. ☐ Appeals support request				
	Additional Services: ☐ JumpStart™ request for patients experiencing a delay in insurance coverage ☐ Rivfloza™ Injection Training: ☐ In-person ☐ Virtual ☐ Starter Kit for new patients starting therapy ☐ NovoCare® Savings Offer (if eligible). For complete terms and conditions, visit RivflozaSavingsEligibility.com .				
	* Terms and conditions of JumpStart™ require active, timely prescriber support of Prior Authorization and/or Appeal documentation submission. † Patients who have been prescribed Rivfloza™ for an FDA-approved indication and who have commercial insurance may be eligible to receive a limited supply of free product from JumpStart™. Patient is not eligible if he/she participates in or seeks reimbursement or submits a claim for reimbursement to any federal or state health care program with prescription drug coverage, such as Medicaid, Medicare, Medigap, VA, DOD, TRICARE, or any similar federal or state health care program. JumpStart™ 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 free product, or (2) resell the free product. No purchase necessary.				
PATIENT/INSURANCE INFORMATION	Patient first name: * _____		Patient last name: * _____		
	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: * _____	Best time to contact: ☐ Morning ☐ Afternoon ☐ Evening	
	Primary guardian/caregiver (required if patient under 18 years old): *				
	DOB (MM/DD/YYYY): _____		Relationship to patient: _____		
	Primary medical insurance: (Please attach a copy of the insurance card, including front & back, if available)		Phone: _____		
	Subscriber name: _____		Subscriber ID: _____	Policy/group #: _____	
	Secondary medical insurance:		Phone: _____		
Subscriber name: _____		Subscriber ID: _____	Policy/group #: _____		
Primary pharmacy insurance: (Please attach a copy of the insurance card, including front & back, if available)		Phone: _____			
Rx # ID: _____		Rx Group #: _____	Rx PCN #: _____	Rx BIN #: _____	
Employer name: _____					
† 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.					
DIAGNOSIS	What is the primary diagnosis for which you are prescribing Rivfloza™ (nedosiran) injection? (required) * ☐ E72.53 - Primary Hyperoxaluria PH Type: * ☐ PH1 ☐ PH2 ☐ PH3 eGFR: * ☐ eGFR ≥30 mL/min/1.73 m2 ☐ eGFR < 30 mL/min/1.73 m2 Weight (kg): * _____ Date: ____ / ____ / ____			Other diagnosis: ☐ ICD-10 code and description: _____ _____	
PRESCRIPTION	If requesting JumpStart™ please select both Prescription fields (required) * ☐ JumpStart™ Prescription ☐ Ongoing Prescription ☐ Both				
	Single Use Pre-filled Syringe: ☐ RIVFLOZA™ (nedosiran) 160mg/1 mL Single Use Pre-filled Syringe ☐ RIVFLOZA™ (nedosiran) 128mg/0.8 mL Single Use Pre-filled Syringe		Vial: ☐ RIVFLOZA™ (nedosiran) 80mg/0.5mL Single use Vial ☐ 1mL syringe with attached 27 gauge, ½" needle (number of syringes should be equivalent to the number of vials needed)		
	Directions: Inject pre-filled syringe SC once a month Quantity _____ Days Supply _____ Refills _____		OR Directions: Inject _____ mg SC once per month Quantity _____ Days Supply _____ Refills _____		
PRESCRIBER AUTHORIZATION	Prescriber name: * _____		License #: * _____		
	Practice name: * _____		Office contact: _____		Preferred method of contact: ☐ Phone ☐ Fax ☐ Email
	DEA #: _____		Tax ID #: _____		NPI #: * _____
	Phone: * _____		Fax: * _____	Email: * _____	
	Address: * _____		City: * _____	State: * _____	Zip: * _____
	Prescriber Attestation: * By signing below, I hereby certify that: (a) I am a licensed practitioner, in good standing under applicable state law; (b) the product being prescribed is to treat a diagnosis(es) consistent with indications and dosing described in the product's prescribing information; (c) the information I have provided on this enrollment form is, to the best of my knowledge, true, complete, and accurate in all respects; and (d) I have obtained authorization from the patient, or the patient's legal representative, to share the patient's personally identifiable health information with Novo Nordisk, Inc. and its vendors, including AssistRx (collectively, "NovoCare") so they may use the information to assist the patient in connection with this prescription, including by contacting the patient using the information provided above. This Personal Information aids in administering the program "NovoCare" by: (i) processing this Application; (ii) verifying my information; (iii) identifying and/or determining eligibility under NovoCare® and other patient assistance resources; (iv) investigating and verifying my insurance benefits; (v) coordinating the dispensing and delivery of medication; (vi) conducting additional services to run NovoCare®; and (vii) conducting quality assurance and/or other internal business activities in connection with NovoCare®. Further, I appoint NovoCare®, on my behalf, to convey this prescription to the dispensing pharmacy. I will immediately notify Novo Nordisk Inc., its employees, or partners, including AssistRx, Inc. (collectively, "NovoCare®") if the above-named patient, or where appropriate the patient's parent, caregiver, and/or legal representative, revokes the authorization they provided, as referred to above. I give you permission to contact me, or the above named patient/Caregiver, with any questions related to NovoCare®.				
	Prescriber signature (no signature stamps): * _____				Date: * _____