SevenSECURE Enrollment Form

Don't wait—enroll today!

When you fill out the following form and return it to the address provided, we'll send you our comprehensive program guide in return! It contains everything you need to get and stay organized while you take full advantage of SevenSECURE services.

Please send your completed form to:
SevenSECURE
PO Box 18648
Louisville, KY 40261
Fax: 1-800-826-6993

Patient Information (please print)

Patient name_____

Parent/guardian name (patients under 18)_____

Address_____

City_____State_____ZIP_____

Home phone_____Work phone_____E-mail address_____

Date of birth_____Patient is: ◯ Male ◯ Female

Patient Authorization and Release

I understand SevenSECURE is a private and confidential program supported by funding from Novo Nordisk Inc. I hereby authorize my healthcare providers and the SevenSECURE program administrators (RxCrossroads™, PSI, and Scholarship Managers) to disclose and share personal data, including relevant medical records and insurance or third-party payer information, that is to be used in enrolling for and obtaining program services. I direct that this authorization be valid while I participate in the SevenSECURE program unless I otherwise notify SevenSECURE in writing.

_____

Patient (parent/guardian) signature Date

◯ Yes, I would like to receive additional information from Novo Nordisk, including details about patient education events and meetings.

Physician Verification of Diagnosis (please print)

Physician name_____Phone_____

HTC/Institution name_____

Please complete the following as it applies to the patient's diagnosis:

◯ Hemophilia A with inhibitors Indicate most recent Bethesda Unit titer (required)_____

◯ Hemophilia B with inhibitors Indicate most recent Bethesda Unit titer (required)_____

◯ FVII Deficiency

I certify that the information provided is accurate to the best of my knowledge.

Physician signature_____Date_____

SevenSECURE™
HERE FOR YOU

novo nordisk®