(levonorgestrel-releasing intrauterine system) 52 mg

PRESCRIPTION & ENROLLMENT FORM

FIVE SIMPLE STEPS TO SUBMIT YOUR REFERRAL

All fields must be completed to facilitate prescription fulfillment

1 SELECT CHOICE OF SPECIALTY PHARMACIES

Specialty Pharmacy	Fax Number	Phone Number	Hours of Operation
❑ Accredo	1.888.355.6682	1.866.759.1557	8:00 AM – 7:00 PM ET
❑ CVS Caremark	1.844.802.1416	1.855.438.2574	8:30 AM – 8:30 PM ET

2 PATIENT INFORMATION

❑ New patient ❑ Current patient

Patient's name ____________ Date of birth ____________

Last 4 digits of SSN ____________ ☑ Female

Street address ____________ Apt # ____________

City ____________ State ____ ZIP code ____________

Parent/guardian (if applicable) ____________

Home phone ____________ Primary phone ____________

Cell phone ____________ Alternate phone ____________

Email address ____________

Patient's primary language:

❑ English ❑ Other If other, please specify ____________

I understand that when my healthcare provider submits my LILETTA Specialty Pharmacy prescription request and enrollment form, the specialty pharmacy will: 1) verify my benefits; 2) collect any copay; 3) ship out my prescription to my healthcare provider. I understand that if I do not sign this form, none of my information will be shared and I may be contacted by the specialty pharmacy, as the request and enrollment cannot be fulfilled without my consent.

❑ I consent to the terms above.

Patient signature ____________ Date ____________

Parent/guardian signature (if applicable) ____________ Date ____________

Please attach front and back of patient's insurance card(s) or complete information below

Patient has no insurance and/or does not want insurance billed. ❑ Request self-pay option

Insurance company ____________ Phone ____________

Insured's name ____________

Insured's employer ____________ Relationship to patient ____________

Identification # ____________ Policy/group # ____________

Prescription card ❑ Yes ❑ No If yes, carrier ____________

Policy # ____________ Group # ____________

Is patient eligible for Medicare?

❑ Yes ❑ No

Does patient have a secondary insurance?

❑ Yes ❑ No

3 CLINICAL INFORMATION

Primary ICD-10 code ____________

Other (list ICD-10 code) ____________

Date of last menses ____________

❑ NKDA ❑ Known drug allergies ____________

Concurrent meds ____________

Requested date of delivery ____________ Scheduled insertion date ____________

4 PRESCRIBER INFORMATION

Date ____________ Time ____________

Prescriber's name and title ____________

If NP or PA, under direction of Dr. ____________

Office contact ____________

Office contact direct phone ____________

Clinic/hospital affiliation ____________

Street address ____________ Suite # ____________

City ____________ State ____ ZIP code ____________

Phone ____________ Fax ____________

NPI # ____________ License # ____________

Deliver product to ❑ Office ❑ Clinic

Clinic location ____________

5 PRESCRIPTION INFORMATION

Medication	Strength/ Formulation	ICD-10	J-Code	NDC	Directions	Quantity
LILETTA (levonorgestrel-releasing intrauterine system)	❑ 52 mg	Z30.014	J7297	0023-5858-01	To be inserted intrauterinely by a healthcare provider	1

When shipped to physician's office, physician accepts on behalf of patient for administration in office. By signing below, I certify that the above therapy is medically necessary.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

Signature ____________ Date ____________

Dispense as written (signature) ____________ Date ____________

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

This form is for patient-specific orders dispensed through a specialty pharmacy. Please contact 1-855-LILETTA (1.855.545.3882) to place a buy and bill order for office stock.

PLEASE FAX THE COMPLETED PRESCRIPTION REQUEST FORM, INCLUDING THE SIGNED AUTHORIZATION SECTION ON PAGE 2, TO: Accredo **1.888.355.6682** CVS Caremark **1.844.802.1416**

(levonorgestrel-releasing intrauterine system) 52 mg

PRESCRIPTION & ENROLLMENT FORM

AUTHORIZATION FOR USE AND RELEASE OF PROTECTED HEALTH INFORMATION

LILETTA® Specialty Pharmacy Program

I authorize my health care provider and all employees, individuals, and entities working with or for such health care provider ("Health Care Providers") to use and/or disclose my personal information, including my personal health information, for the following purposes: to operate and administer the LILETTA Specialty Pharmacy Program.

In order for Allergan to operate and administer the LILETTA Specialty Pharmacy Program, I understand that Allergan will need my personal information and my health information, which may include my name, information about my health condition, my treatment and product information, treatment dates, eligible treatment type, my medical history and general health, my health care plan benefits and coverage, information about my adherence to my treatment, and other relevant personal and health information ("Personal Health Information"). I authorize my Health Care Providers who have my Personal Health Information to release and disclose my Personal Health Information to Allergan only for the purposes set forth above, including operating and administering the LILETTA Specialty Pharmacy Program.

My Health Care Providers may release my Personal Health Information in whatever form and through whatever media, including the internet, as required by the purposes set forth.

My Health Care Providers and Allergan will ensure that reasonable and appropriate physical, procedural, and technological safeguards are in place in order to protect my Personal Health Information from inadvertent destruction, disclosure, or unauthorized access.

I further understand that once my Health Care Providers disclose my Personal Health Information to Allergan, it may no longer be covered by federal privacy regulations, and, therefore, could be re-disclosed. However, Allergan agrees to protect my Personal Health Information by only using and disclosing it as stated in this Authorization or as otherwise allowed or required by law.

I understand that I may receive a copy of this authorization or revoke this Authorization at any time by calling or writing to:

[Health Care Provider: Please fill in for patient]

Name ______________________________

Office Name ______________________________

Address ______________________________

____

Telephone ______________________________

I further understand that if my Health Care Providers are disclosing my Personal Health Information to Allergan, my revocation of this Authorization will only prevent further disclosure of my Personal Health Information to Allergan by such Health Care Providers after they receive notice of my revocation.

I understand that this Authorization is voluntary and I may refuse to sign it. My refusal to sign will not affect my ability to obtain treatment or payment for my treatment.

I understand that this Authorization for my Health Care Providers to disclose my Personal Health Information will not expire unless I notify my Health Care Providers to terminate it, or unless another date is specified herein, or is required by state or other applicable law(s).

One copy of this Authorization will be kept by your Health Care Providers. You will receive a copy of the Authorization that you have signed and dated.

I have read and understood this Authorization, and agree to the use and release of my Personal Health Information according to the terms written above.

Patient Name ______________________________

Patient Signature ______________________________

Date ______________________________

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LLT107734 05/17