





Patient Referral Form



PARAGARD
Benefits Verification



PARAGARD
Specialty Pharmacy



PARAGARD Benefits Verification	ARAGARD Specialty Pharmacy SM ☐ PARAGARD Patient Direct TM (Patient Self-Pay)
Patient Information	ICD-10 Coding
First Name:	Z30.430 Encounter for insertion of intrauterine
Last Name:	contraceptive device
Middle Initial:	Other Please specify:
Date of Birth:	
Street Address:	J code: J7300
	Group Number:
City: State:	Subscriber DOB:
ZIP:	Employer Name:
Phone:	
Alternate Phone:	Healthcare Provider Information
Scheduled Placement Date:	Prescriber Name:
Section (Control of Control of Co	Specialty:
Insurance Information N/A (Patient Self-Pay)	Group or Hospital:
(Please attach copies of the front and back of medical and	Contact Name:
prescription drug insurance cards with request.)	Street Address:
Primary Insurer:	City: State:
Phone Number:	ZIP:
Subscriber Name:	Phone:
Subscriber ID:	Fax:
RxBIN:	NPI:
RxPCN:	Tax ID:
RxGrp:	
How do you intend to obtain PARAGARD®?	
N/A, Paragard Benefits Verification SM Only Paragard Direct [™] (Buy & Bill)	PARAGARD Specialty Pharmacy SM PARAGARD Patient Direct [™] (Patient Self-Pay)
PARAGARD Specialty Pharmacy ^{sм} NOTIFICATION: By submitting this preso box above, prescriber and patient are aware that Biologics, Inc. will ship upon	
Would you like a benefits verification report sent to your	office before sending to the pharmacy?
Yes No	
R PARAGARD® Prescriber must call 1-888-275-8596 to cancel shipn	nent.
Paragard® T 380A Qty: 1	
To be inserted one time by prescriber. Route intrauterine. Requested	d date of delivery:
Prescriber gives Biologics, Inc. express permission to use his/her NPI number included lobenefits manager and/or payer. Biologics, Inc. accepts no liability regarding any decishealth plan administrators and insurers. Biologics, Inc. makes no assurance that any pany pharmacy will provide the prescribed drug or treatment.	sions concerning claims coverage or payment, which remain the responsibility of the
Prescriber Signature:	Date:
For ARNP, NP, and PA, collaborative physician agreement is with:	Date:

PARAGARD[®] is a registered trademark, PARAGARD Access Solutions™, PARAGARD Direct™, and PARAGARD Patient Direct™ are trademarks, and PARAGARD Benefits VerificationSM and PARAGARD Specialty PharmacySM are service marks of Teva Women's Health, Inc.

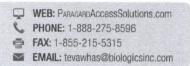
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Women's Health







Patient Authorization Form







PARAGARD®

In accordance with the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules ("HIPAA"), this Authorization authorizes my healthcare provider, health plan, and my pharmacy to disclose my health and personal information to Teva Women's Health, Inc. and its agent, Biologics, Inc. (and its affiliates, and their respective representatives, and agents [collectively, "Biologics"]) in furtherance of the below-stated authorized purposes. The "Paragard Access SolutionsTM" program is operated by Biologics on behalf of Teva Women's Health, Inc.

Authorized Purposes

I understand that Paragard Access SolutionsTM Program and Biologics will receive my health and personal information for the following purposes: (1) to conduct benefit verification determining insurance reimbursement and coverage of Paragard*; (2) if my physician selects that the Paragard* unit is shipped by a specialty pharmacy, to contact me to discuss any relevant co-pay, to bill the insurance company, to bill the applicable co-pay and to ship the unit to my healthcare provider; (3) to contact me by telephone in furtherance of conducting benefits verifications investigations; and (4) if I select the Paragard Patient DirectTM self-pay option, to invoice me and to otherwise contact me to collect payment for the Paragard unit.

By signing the following form, I understand:

- Once my healthcare provider gives Biologics and the PARAGARD Access Solutions™ Program information about me based on this Authorization, my medical and health information may be subject to redisclosure and is no longer protected by federal privacy regulations.
 - I further understand and agree that Biologics and the Paragard Access Solutions™ Program may retain my medical and health information as disclosed under this Authorization after this authorization expires.
 - I also understand that in the event of an audit, and for purposes of such an audit, some information may also be disclosed to Teva Women's Health, Inc., the manufacturer of Paragard, or its affiliates after this Authorization has expired, so long as the audit is for a period of time when this Authorization was in effect.
- 2. I may refuse to sign this Authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my healthcare provider; or to seek payment; or my eligibility for insurance benefits.
- 3. I may revoke my authorization at any time by providing a written notice of same to my healthcare provider that refers to (or with a copy of) this Authorization form, or to Biologics/the Paragard Access Solutions™ Program at 120 Weston Oaks Court, Cary, NC 27513. However, I understand that if I revoke this authorization, it will not affect prior disclosures made by my healthcare provider to Biologics and any use of such information by Biologics in reliance of this authorization. I understand that I have the right to receive a copy of this Authorization.
- 4. This Authorization shall expire one year after I have signed it, or upon revocation, whichever is earlier.

Signature of Patient or Personal Representative	Date
Name of Patient or Personal Representative	
(If Applicable) Description of Personal Representative's Authority to Sign for Patient	

