



(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
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
Table with columns: Medication, Strength/Formulation, ICD-10, J-Code, NDC, Directions, Quantity.
Row 1: 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.



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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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