Kyleena Mirena Skyla

Bayer Women's HealthCare Support Specialty Pharmacy Prescription Request Form

Specialty Pharmacy	Fax	Phone	Hours of Operation
☐ CVS Specialty (In the Continental US)	(866) 216-1681	(866) 698-8312	7:30 AM – 9:00 PM ET
☐ CVS Specialty (In Hawaii-Neighbor Islands)	(877) 232-5455	(800) 896-1464	8:00 AM – 6:00 PM HT
☐ CVS Specialty (In Hawaii-Oahu)	(877) 232-5455	(808) 254-2727	8:00 AM – 6:00 PM HT
☐ AllianceRx Walgreens Prime*	(800) 830-5292	(877) 686-4633	8:00 AM – 8:00 PM ET
☐ Humana Specialty Pharmacy**	(877) 405-7940	(800) 486-2668	8:00 AM – 8:00 PM ET
☐ Magellan Rx Specialty Pharmacy	(866) 364-2673	(866) 554-2673	8:00 AM – 7:00 PM ET

*Includes Tricare East **Includes Tricare West

Patient Information

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Alternate Phone: _____ Primary Language: _____ Gender: _____

Prescription Information

By submitting this prescription request form, prescriber and patient are aware that the Specialty Pharmacy will ship upon verification of benefits and collection of applicable co-pay. If there is a zero-dollar co-pay, patient may not be contacted. The Specialty Pharmacy will ship to prescriber's office, and will not contact prescriber before shipping.

☐ Rx Kyleena ☐ Rx Mirena ☐ Rx Skyla

Kyleena (ICD-10): ☐ Z30.430
Other (List ICD-10): _____
SIG: To be inserted one time by prescriber.
Route intrauterine
Quantity: 1
- Date of last menses: _____
- List Allergies: _____
- Requested Date of Delivery: _____
- Scheduled Insertion Date: _____
- Product Substitution Permitted (Signature) Date

_____
Dispense as Written (Signature) Date

☐ I have previously received an IUS Educational Kit
☐ I would like to receive an IUS Educational Kit
- For ARNP, NP, and PA, collaborative physician agreement is with: _____

Mirena (ICD-10): ☐ Z30.430 ☐ N92.0 ☐ N92.4
Other (List ICD-10): _____
SIG: To be inserted one time by prescriber.
Route intrauterine
Quantity: 1
- Date of last menses: _____
- List Allergies: _____
- Requested Date of Delivery: _____
- Scheduled Insertion Date: _____
- Product Substitution Permitted (Signature) Date

_____
Dispense as Written (Signature) Date

☐ I have previously received an IUS Educational Kit
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- For ARNP, NP, and PA, collaborative physician agreement is with: _____

Skyla (ICD-10): ☐ Z30.430
Other (List ICD-10): _____
SIG: To be inserted one time by prescriber.
Route intrauterine
Quantity: 1
- Date of last menses: _____
- List Allergies: _____
- Requested Date of Delivery: _____
- Scheduled Insertion Date: _____
- Product Substitution Permitted (Signature) Date

_____
Dispense as Written (Signature) Date

☐ I have previously received an IUS Educational Kit
☐ I would like to receive an IUS Educational Kit
- For ARNP, NP, and PA, collaborative physician agreement is with: _____

Prescriber Information

Prescriber Name (Last, First): _____ Title (please check one) ☐ MD ☐ DO ☐ NP ☐ PA

Office Contact: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Ship to address if different from above: _____ DEA #: _____

Group or Hospital: _____ Physician Medicaid #: _____ License #: _____ NPI #: _____

If covered through Buy and Bill, Physician ☐ will accept Buy and Bill coverage.

Please see Important Safety Information for Kyleena, Mirena or Skyla on third page and accompanying full Prescribing Information for Kyleena, Mirena and Skyla.

[illegible]

[illegible]

(Please copy and attach the front and back of medical and prescription insurance cards - Send with request)

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

Prescription Insurance: _____

Phone: _____

Subscriber #: _____ Group #: _____

Policy Holder Information (if different from patient)

Name: _____ Employer: _____

Relation to Patient: _____

Medical Insurance: _____

Phone: _____

Subscriber #: _____ Group #: _____

Policy Holder Information (if different from patient)

Name: _____ Employer: _____

Relation to Patient: _____

PLEASE FAX THE PRESCRIPTION REQUEST FORM, INCLUDING THE SIGNED PATIENT AUTHORIZATION SECTION ON PAGE 4.

Please see Important Safety Information for Kyleena, Mirena or Skyla on third page and accompanying full Prescribing Information for Kyleena, Mirena and Skyla.

The Specialty Pharmacy Program prescription process

To order Kyleena, Mirena or Skyla, complete the Specialty Pharmacy Prescription Request Form as follows:

1. Select Specialty Pharmacy.
2. Enter the patient and prescriber information in the space provided on the Specialty Pharmacy Prescription Request Form, including the patient's pharmacy drug benefit and medical insurance information.
   - Please ensure that all information is complete
   - Include copies of the patient's pharmacy benefit and medical insurance cards
   - Prescriber information (complete this information and then photocopy the form for future use)
3. Complete the prescription section.
   - Indicate if Kyleena, Mirena or Skyla will be administered
   - Indicate appropriate diagnosis code
   - Sign the prescription
   - For ARNP, NP, and PA, identify who your collaborative agreement is with if requested to write prescriptions in your state
4. Have the patient read and sign the Patient Authorization section of the form and fax it to the appropriate SP with the SP request form.
5. Finalize the prescription request and prepare for your patient's Kyleena, Mirena or Skyla insertion.
   a. Fax the completed Prescription Form, including the Patient Authorization section, to either CVS Specialty (Continental US 1-866-216-1681; Hawaii-Neighbor Islands 1-877-232-5455; Hawaii-Oahu 1-808-254-4445), AllianceRx Walgreens Prime (Tricare East) 1-800-830-5292, Humana Specialty Pharmacy (Tricare West) 1-877-405-7940, or Magellan Rx Specialty Pharmacy 1-866-364-2673.
   For questions call 1-866-638-8312 for CVS Specialty in the Continental US, 1-800-896-1464 in Hawaii-Neighbor Islands, and 1-877-232-5455 in Hawaii-Oahu; 1-877-686-4633 for AllianceRx Walgreens Prime (Tricare East), 1-800-486-2668 for Humana Specialty Pharmacy (Tricare West); and 1-866-554-2673 for Magellan Rx Specialty Pharmacy.
   b. Bill the patient's insurance for the procedure and your customary professional services charges only.

To find out more about the Specialty Pharmacy Program or to request prescription forms, contact your Bayer Sales Consultant or visit our website at www.whcsupport.com for more information.

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Patient Authorization

I authorize the use and/or disclosure of my private health information, described below, which may include "Protected Health Information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). In general terms, I understand that Protected Health Information is health information that identifies me or that could reasonably be used to identify me. I understand that this authorization is voluntary.

I authorize my healthcare providers, including my physicians, pharmacies, and my health plan insurers to share my name, address, and phone number along with my prescription, medical diagnosis, treatment, and insurance information with Bayer and its agents and contractors. These agents include a company that provides reports to Bayer on sales of Kyleena®, Mirena® and Skyla® and a company that provides quality control and checks the accuracy of reports on sales of Kyleena, Mirena or Skyla (collectively "Bayer").

I understand that certain healthcare providers, such as my pharmacies, may receive payment from Bayer in connection with the disclosure of my PHI as described in this authorization.

I allow the use of my PHI and the sharing of my PHI to: 1) communicate with me, my healthcare providers, and health plans about my medical care, including treatment with Kyleena, Mirena or Skyla; 2) provide information on coverage and reimbursement of Kyleena, Mirena or Skyla to me and my healthcare providers; 3) facilitate returns of Kyleena, Mirena or Skyla; 4) be used for sales purposes, including to evaluate healthcare provider prescribing patterns; and 5) comply with applicable law.

I understand that any personal information provided on this form will not be used for any purposes other than those described above unless I give written consent, or it is required or permitted under the law, and my name and all other identifying information is removed.

This authorization will remain in effect for 1 year after the date I sign it and will expire after 1 year unless I revoke it prior to this time. I can withdraw (ie, take back) this authorization earlier by sending a written request to Bayer Healthcare Pharmaceuticals, Attn: Medical Communications, 100 Bayer Boulevard, Whippany, NJ 07981 (Fax# 973-305-3560), except to the extent my healthcare provider or health plan has taken action in reliance on my authorization. I understand that if I revoke this authorization, it will not have any effect on any actions my healthcare providers or my health plan may have taken before receiving the revocation, and will not affect Bayer's ability to use and disclose any information it has already received.

I also understand that persons or entities that receive my PHI under this authorization may not be required by privacy laws (such as the HIPAA Privacy Rule) to protect the information and may share it with others without my permission, if permitted by laws applicable to them.

I may refuse to sign this form, and refusal will not affect my treatment, payment for treatment, enrollment in a health plan, or eligibility for benefits.

I have read this entire authorization and/or had its contents read to me. I have had an opportunity to ask questions about the uses and disclosures of PHI described above, and all of my questions have been answered to my satisfaction. I authorize the use and disclosure of my information as described in this form. I understand that I am entitled to receive a signed copy of this authorization.

Printed name of individual or individual's representative _____ Date _____

Signature of individual or individual's representative _____ Date _____

If signed by the individual's representative, a description of the representative's relationship to the individual and such person's authority to act for the individual (eg, parent, guardian, etc)

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