Customer Support Center

Nexplanon®
(etonogestrel implant) 68mg
Radiopaque

Enrollment Form

Version 2.0

Phone: 844-NEX-4321 (844-639-4321) • Fax: 844-232-2618

TO GET STARTED, COMPLETE THE ENROLLMENT FORM AND FAX IT TO 844-232-2618.

PLEASE CHECK ALL BOXES THAT APPLY AND COMPLETE THE APPROPRIATE SECTION(S) OF THIS FORM

☐ Patient Benefit Investigation ☒ Prescription Order

SPECIALTY PHARMACY PREFERENCE (ONLY REQUIRED IF "PRESCRIPTION ORDER" IS REQUESTED ABOVE)

Please select **one** fulfillment option to indicate your preference.

☐ Accredo Health Group Inc. ☐ AllianceRx Walgreens Pharmacy ☐ ASPN Pharmacies, LLC

☐ CVS Specialty Pharmacy ☐ CenterWell Specialty Pharmacy ☐ Magellan Rx Pharmacy

Note: If the patient's insurer requires use of a particular specialty pharmacy, or if it is determined that the specialty pharmacy selected is not within the insurer's network, the CSCN will automatically triage the script to the required specialty pharmacy, or to an in-network specialty pharmacy.

If no selection is made, or if multiple specialty pharmacies are selected, the CSCN will triage to an in-network specialty pharmacy, if known. If unknown, the CSCN will contact your office to obtain the preferred specialty pharmacy.

PATIENT INFORMATION SECTION

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Primary Language: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ ☐ Home ☐ Cell Email: _____

Special Instructions: _____

Current Medications: _____

INSURANCE INFORMATION

PLEASE COMPLETE ALL THAT APPLY AND INCLUDE A FRONT AND BACK COPY OF INSURANCE CARD FOR EACH TYPE OF INSURANCE

☐ **Patient has no insurance and/or does not want insurance billed. Requests for Self Pay option available at preferred Specialty Pharmacy.**

Prescription Drug Card

Plan Name: _____

Payer Phone: _____ BIN: _____

PCN: _____ Policy #: _____ Group #: _____

Policy Holder Information (If different from patient)

Name: _____

Date of Birth: _____

Employer: _____

Relationship to Patient: _____

Medical Insurance

Plan Name: _____

Payer Phone: _____

Policy #: _____ Group #: _____

Policy Holder Information (If different from patient)

Name: _____

Date of Birth: _____

Employer: _____

Relationship to Patient: _____

PATIENT INFORMATION SECTION

PATIENT AUTHORIZATION (REQUIRED if "Prescription Order" has been requested above)

I understand that in order for Organon LLC, a subsidiary of Organon & Co. ("Organon") and PharmaCord, LLC (the company that will conduct reimbursement support on behalf of Organon) to provide me with assistance, PharmaCord, LLC and its administrators (collectively, "PharmaCord, LLC") will need to obtain, review, use, and disclose my personal health information related to my treatment with NEXPLANON® (etonogestrel implant), information on my request form, and any prescription for NEXPLANON (my "PHI"). I authorize my physician, pharmacy(ies), and my health plan(s) to disclose my PHI to PharmaCord, LLC as necessary to complete the insurance investigation process. I further authorize PharmaCord, LLC and the Specialty Pharmacies (Accredo Health Group Inc., AllianceRx Walgreens Pharmacy, ASPN Pharmacies, LLC, CVS Specialty Pharmacy, CenterWell Specialty Pharmacy, or Magellan Rx Pharmacy) and their respective affiliates to exchange my PHI to provide support and to disclose the information to my health plan(s) and their contractors for the purpose of coordination of benefits, reimbursement support, investigating insurance coverage and coordination of the delivery, receipt and storage of my prescription medication for NEXPLANON for the sole purpose of administration to me by my prescribing provider named above.

I authorize the Specialty Pharmacy and PharmaCord, LLC to use my PHI to contact me via mail, telephone, text, or email in connection with information related to this Enrollment Form. If contacted by the Specialty Pharmacy and/or PharmaCord, LLC via text, I understand that standard data rates apply. In order for the Specialty Pharmacy to ship my prescription medication for NEXPLANON directly to my prescribing provider, I authorize the Specialty Pharmacy to communicate with my prescribing provider about my PHI in order to coordinate the delivery, receipt, and storage of my prescription medication for NEXPLANON for the sole purpose of administration of my prescribing provider at my next scheduled appointment. If there is a $0 co-pay, my signature below serves as my consent for the Specialty Pharmacy to ship my prescription medication to my prescribing provider. I understand that my PHI disclosed pursuant to this Authorization may no longer be protected by certain federal privacy laws and may be re-disclosed by the recipient, but that PharmaCord, LLC has agreed to use my PHI only for the purposes described herein.

I understand that if I do not sign this Authorization, that will not affect my receipt of treatment (including with NEXPLANON) or of health insurance benefits, but that I will not be able to obtain certain assistance provided by PharmaCord, LLC on behalf of Organon. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to CSCN, PO Box 1566, Jeffersonville, IN 47131. I understand that canceling my Authorization will not affect uses and disclosures of PHI already made in reliance on the Authorization before my cancellation is received by PharmaCord, LLC.

If I do not cancel this Authorization, the Authorization will expire 15 months from the date of signature (or the maximum period allowed by applicable state law, if less than 15 months). Organon has retained PharmaCord, LLC and the Specialty Pharmacies to provide support to customers, including reimbursement support. Information and questions related to the information provided in regard to this request should be referred directly to PharmaCord, LLC. Organon personnel are not aware of patient-specific reimbursement information and are not permitted to discuss such information with customers. I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

Patient Signature: _____ **Date:** _____

Patient Name: _____

Patient Date of Birth: _____

Relationship to patient if signing on their behalf: _____

If you have questions about completing this form or need additional information, please call 844-NEX-4321 (844-639-4321). Thank you.