Liletta® (levonorgestrel-releasing intrauterine system) 52 mg

PRESCRIPTION & ENROLLMENT FORM

accredo® CVS specialty™

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**

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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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