

Patient Referral Form



PARAGARD
Benefits Verification[™]



PARAGARD
Specialty Pharmacy[™]



PARAGARD
Patient Direct[™]

Service Requested PARAGARD Benefits VerificationSM PARAGARD Specialty PharmacySM PARAGARD Patient Direct[™]
(check only those that apply) (Patient Self-Pay)

FOR PATIENT

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____
Street Address: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Alternate Phone: _____ Scheduled Placement Date: _____

Insurance Information N/A (Patient Self-Pay)

(Please attach copies of the front and back of medical and prescription drug insurance cards with request.)

Primary Insurer: _____ Phone Number: _____
Subscriber Name: _____ Subscriber ID: _____
RxBIN: _____ RxPCN: _____ RxGrp: _____

FOR HEALTHCARE PROFESSIONAL

Prescriber Name: _____ Specialty: _____
Group or Hospital: _____ Contact Name: _____
Street Address: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
NPI: _____ Tax ID: _____

J code: J7300

Group Number: _____ Subscriber DOB: _____ Employer Name: _____

ICD-10 Coding

Please specify ICD-10 Code(s): _____

How do you intend to obtain PARAGARD?

N/A, PARAGARD Benefits VerificationSM Only PARAGARD Direct[™]
(Buy & Bill) PARAGARD Specialty PharmacySM PARAGARD Patient Direct[™]
(Patient Self-Pay)

PARAGARD Specialty PharmacySM NOTIFICATION: By submitting this prescription request form and checking the PARAGARD Specialty PharmacySM box above, prescriber and patient are aware that Biologics, Inc. will ship upon verification of benefits and collection of applicable co-pay.

Would you like a benefits verification report sent to your office before sending to the pharmacy? Yes No

If your patient is a minor and is signing the authorization on the following page on her own behalf, please affirm that:

- This patient has the capacity to consent to treatment with PARAGARD under the law of the state in which I practice (and the consent of a parent or guardian is not required), or
- This patient's parent or guardian has consented to the patient's treatment with PARAGARD (Does not apply to the following: Alaska, Arkansas, California, Colorado, District of Columbia, Georgia, Idaho, Iowa, Kentucky, Maryland, Minnesota, North Carolina, New Mexico, Oregon, Tennessee, or Virginia)

R **PARAGARD** Prescriber must call 1-888-275-8596 to cancel shipment. PARAGARD T 380A Qty: 1

To be inserted one time by prescriber. Route intrauterine. Requested date of delivery: _____

Prescriber gives Biologics, Inc. express permission to use his/her NPI number included herein for the purpose of identifying the referring prescriber to the authorized pharmacy benefits manager and/or payer. Biologics, Inc. accepts no liability regarding any decisions concerning claims coverage or payment, which remain the responsibility of the health plan administrators and insurers. Biologics, Inc. makes no assurance that any prescribed drug or treatment will be covered under any patient's insurance plan or that any pharmacy will provide the prescribed drug or treatment.

Prescriber Signature: _____ Date: _____

For ARNP, NP, and PA, collaborative physician agreement is with: _____ Date: _____

Patient Authorization Form



PARAGARD
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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 Solutions™” program is operated by Biologics on behalf of Teva Women’s Health, Inc.

Authorized Purposes

I understand that PARAGARD Access Solutions™ 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 Direct™ 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:

1. 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 11800 Weston Parkway, 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
