IMPLANON® Direct Service Request Form

Phone: 866-318-3492 Fax: 866-769-3882

IMPLANON® (etonogestrel implant) 68 mg

Services Requested: ❑ **Benefit Verification** ❑ **Prescription Order** ❑ **Buy and Bill Purchase**

Patient Benefit Verification and/or Prescription Order (For Patient Pharmacy Benefit)

Patient Information

Last Name: ______ First Name: ______ MI: ___ DOB: ______
Address: ______ City: ______ State: ______ Zip Code: ______
Phone: ______ SSN: ______

Patient Insurance Information

Primary Insurance: ______
Phone: ______
Policy #: ______ Group #: ______
Policy Holder Information (If different from patient)
Name: ______
Employer: ______ SS#: ______
Relation to Patient: ______

Secondary Insurance: ______
Phone: ______
Policy #: ______ Group #: ______
Name: ______
Employer: ______ SS#: ______
Relation to Patient: ______

Prescriber Information *(IMPLANON®-trained clinician)*

Prescriber Name (First, Last): ______ Name of Practice: ______
Office Contact: ______ Phone: ______ Fax: ______
Address: ______ City: ______ State: ______ Zip Code: ______
Email: ______ State Medical License #: ______ NPI #: ______
Contact Preference: ❑ Phone ❑ Fax ❑ Email

Prescriber Authorization

I authorize Caremark, L.L.C. or its affiliates to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any of my patients for whom I intend to prescribe IMPLANON® to the insurer of such patients and to obtain any information about such patients, including any protected health information (as defined in 45 CFR 160) from the insurer, including eligibility and other benefit coverage information, for my payment and/or health care operation purposes. As my business associate, Caremark, LLC is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR 164.504(e) regarding business associates, and that it will safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

Prescriber's Signature: ______ **Date:** ______

Prescription Information *(Patient-Specific Order for specialty pharmacy dispensing)*

Rx IMPLANON® (etonogestrel implant) 68 mg ❑ V25.5 ❑ V25.43 ❑ V45.52 ❑ Other: ______

❑ Dispense ______ **IMPLANON®** SIG: **To be inserted by physician as directed**

Additional Instructions: ______

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge. I certify that I have completed an IMPLANON® training program.

Prescriber's Signature: ______ **Date:** ______

Purchase IMPLANON® (For Medical Benefit/Buy and Bill)

Wholesale Purchasing *(Prescriber purchases, billed to the prescriber)*

Ship to: ❑ Prescriber's Address Above ❑ Address Below Account Number: ______
Physician, Institution or Practice Name: ______
Address: ______ City: ______ State: ______ Zip Code: ______
Phone Number: ______ Contact Name: ______

Bill to Address - Account Holder (If different than shipping information)
Physician, Institution or Practice Name: ______
Address: ______ City: ______ State: ______ Zip Code: ______
Phone Number: ______ Contact Name: ______

Quantity Requested Name: IMPLANON® NDC: 00052-0272-01 Quantity: ______
Purchase Order # (if required by practice or institution): ______
Credit Card: Name on Card: ______ Account #: ______ Exp. Date: ______
Requested Delivery Date: ______
Form of Business: ❑ Hospital ❑ Private Practice ❑ PHS (340B) ❑ Sub PHS (340B Prime Vendor) ❑ FSS (DoD, VA, IHS) ❑ Planned Parenthood ❑ Other (please specify): ______
Tax Identification Number: FEIN: ______ SSN: ______ *(If FEIN not available)*

Signature Authorization

Provider will be invoiced for all products [IMPLANON®] purchased from Caremark, LLC at the rates quoted at the point-of-sale. Provider is financially responsible for, and agrees to pay, Caremark, LLC all invoiced charges for products ordered by Provider. Each invoice will be due and payable by Provider within the payment terms offered by Caremark, LLC on the date-of-order.

Signature: ______ Print Name and Title: ______ Date: ______

If different from signature, provide the name of the IMPLANON® trained clinician responsible for this order: ______

Fax to: IMPLANON® Direct at 866-769-3882

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CVS CAREMARK

Important Instructions

When completing/submitting your IMPLANON® Direct Service Request Form

CVS Caremark can verify patient benefits on behalf of the prescriber. To expedite this process, please take a moment to read these instructions and complete each section of the form.

1 Patient Benefit Verification

NOTE: Please notify your patients that CVS Caremark will attempt to reach them by phone to verify their acceptance of the product.

PATIENT INFORMATION: Please provide complete contact information for the patient.

PRESCRIBER: The prescriber listed on the form must be trained in the insertion and removal of IMPLANON®.

PRESCRIPTION AUTHORIZATION: The authorization allows IMPLANON® Direct to investigate the patient's insurance coverage acting on behalf of the physician. Please sign in the designated area.

2 Prescription Information

NOTE: To order IMPLANON® by prescription for a participating patient, please complete the prescription section, in addition to patient information, patient insurance information, and prescriber information sections.

PRESCRIBER SIGNATURE: The individual signing this form must be the trained clinician who will be inserting IMPLANON®.

NOTE: If your patient will be paying by cash, you may use this form as a prescription. Please write "cash" under the "Insurance Information" portion of this form.

3 Buy and Bill Purchase

NOTE: To purchase IMPLANON® for Buy and Bill, complete this section. If you have a scheduled insertion, please indicate in the space provided. This will allow IMPLANON® Direct to ensure that IMPLANON® is received on time.

SIGNATURE AUTHORIZATION: Buy and Bill purchases must be authorized by an individual with purchasing authority.

If this person is not an IMPLANON® trained clinician, please identify the IMPLANON® trained clinician responsible for the order.

4 Faxing the Form

Please fax the completed form, along with both sides of the patient's insurance card, to 866-769-3882.

Before submitting, remember to....

- ❑ Indicate services requested
- ❑ Fill in the patient's information, including Social Security number
- ❑ Make sure the prescriber listed on the form is trained in inserting IMPLANON®
- ❑ Accurately and thoroughly complete the Insurance Information section, including all corresponding codes
- ❑ Fax the completed form along with both sides of the patient's insurance card
- ❑ **To contact IMPLANON® Direct with any questions or concerns, please call 866-318-3492**

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www.IMPLANON-USA.com