

## Direct Service Request Form Phone: 866-318-3492 Fax: 866-769-3882

# IMPLANON® (etonogestrel implant) 68 mg

NEXPLANON® (etonogestrel implant)

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

Requested Services	Product: ☐ NEXPLANON ☐ IMPLANON Services Requested: ☐ Benefit Verification ☐ Prescr	ription Order 🚨 Buy a	and Bill Purchase					
					2011			
Patient	Last Name: First Name: Address:	City	MI:	DOB:	SSN:			
Information	Address:							
	Prione:	Alternative Phone:		P	rimary Language:			
Patient	Prescription Drug Card:							
Insurance	Phone: BIN:		Phone:					
Information	PCN: Policy #:	-Group #:	Policy #:		Group #:			
Copy and attach front	Policy Holder Information (If different from patient)							
and back of insurance	Name:							
card and prescription	Employer: SS#:		Employer:		SS#:			
drug card	Relation to Patient:		Relation to Patient:					
	Patient has no insurance and/or does not want insurance bille	ed. Requests Self Pay opti	on: 🗖 Single payme	ent 🚨 3-month pa	ayment plan			
Authorization (For benefit investigation request only)	and disclose my personal health information (PHI), including in physician, pharmacy(ies) and my health plan(s) to disclose my authorize Caremark L.L.C. and their administrators to use my PH the purpose of coordination of benefits, reimbursement suppor prescription medication for the sole purpose of administration INEXPLANON at his/her medical facility.  I agree to allow Caremark L.L.C. to contact me via mail, telephoi identifying information provided in my request form will be av protected by privacy laws and may be re-disclosed by Caremark	PHI to Caremark L.L.C. an Il to provide services throu- rt, investigating insurance by my prescribing provide me, or email in connection railable to Caremark L.L.C.	d their administrators igh this program, and coverage and to coor r. The prescribing pro with carrying out the , and their affiliates.	s as necessary to co to disclose the info dinate the delivery, ovider listed below ese services. I unde I understand that n	omplete the insurance in ormation to my health pl , receipt and storage of r is my healthcare agent v erstand that my name, ac my PHI disclosed under t	nvestigation process. I further an(s), and their contractors for my IMPLANON or NEXPLANON who administers IMPLANON or Medical states and any other personal this request may no longer be		
	requesting assistance with insurance coverage may be summar from such summary information.  I understand that if I don't provide an Authorization, I will not be this Authorization at any time by mailing a written request for apply to any information already used or disclosed pursuant to t If I don't cancel this Authorization, the Authorization will expire reimbursement services. Information and questions related to not aware of patient specific reimbursement information and a	able to obtain service pro such cancellation to my p this Authorization. 15 months from the date the information provided re not permitted to discus	gram assistance provi rescribing physician, p signed below. Merch I in regard to this req	ded by Caremark, L oharmacy, health p k has retained Carei uest should be refu	L.C. on behalf of Merck. plans and Caremark L.L.C mark L.L.C. to provide se erred directly to Carema	I understand that I may cance ,, and the cancellation will not ervices to customers, including rrk L.L.C. Merck personnel are		
	understand that I may request a copy of this Authorization once	-						
	Patient signature:							
	Signature of legal representative (if applicable)		Date://	<u>′                                    </u>				
Prescriber	Prescriber Name (First, Last):			Title: 🔲 M[	D DO NP D	PA		
Information	Name of Practice:							
(IMPLANON OR	Office Contact:							
NEXPLANON	Address:							
-trained clinician)	Email:				ate:			
	NPI #:							
	For ARNP, NP & PA, collaborative physician agreement is with:	:		Date:				
Prescription Information (Patient-Specific Order for specialty pharmacy	Dispense _1_							
dispensing)	Product Substitution Permitted (signature)	Dat	e Dispense	as written (signatu	ure)	Date		
						Date		
	Allergies:				ite of Last Menses:			
	I certify that I have completed an IMPLANON training program If not certified, please contact your sales representative.	if ordering IMPLANON, a		eted NEXPLANON	training if ordering NEX	(PLANON.		
	Prescriber's Signature:	Date:						
	Notification: By submitting this proscription request form pros	cribar is awara that CVS C	aromark will chin	on varification of h	onofits and collection s	fannlicable consulf there		

is a zero-dollar copay, patient will not be contacted. CVS Caremark will ship to prescriber's office, and will not contact prescriber before shipping.



#### **Buy and Bill Order Form**

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

#### IMPLANON® (etonogestrel implant) 68 mg

**NEXPLANON**<sup>®</sup> (etonogestrel implant)

	Purchase of IMP	LANON and/or NEXPLANON (Buy and Bill)	
Prescriber Information	Prescriber Name (First, Last):		Title: □ MD □ DO □ NP □ PA
(IMPLANON OR	Name of Practice:		
NEXPLANON-	Office Contact:	Phone:	Fax:
trained clinician)	Address:	City:	State: Zip Code:
	Email:	State Medical License #:	Expiration Date:
	NPI #:	. Contact Preference: 🗖 Phone 📮 Fax 📮 Er	mail
	For ARNP, NP & PA, collaborative physician agreement is with	·	Date:
Shipping	Ship to: ☐ Prescriber's Address Above ☐ Address Below	Requested	d Delivery Date:
Information	Prescriber, Institution or Practice Name:		
	Address:	City:	State: Zip Code:
	Phone Number:	Contact Name:	
	CVS Caremark will invoice Purchaser at the time of each shipn CVS Caremark's related invoice ("Payment Due Date"). Purcha:	,	
D 0 D!II	Bill to Address - Account Holder (If different than shipping	information)	
Buy & Bill (Prescriber purchases, billed to the prescriber)	Physician, Institution or Practice Name:		_ HIN:
	Address:	City:	State: Zip Code:
	Phone Number:	Contact Name:	
	Quantity Requested: PRODUCT: IMPLANON	NDC: 00052-0272-01 Purchase Order # (if rec	quired by practice or institution):
	Quantity Requested: PRODUCT: NEXPLANON	NDC: 00052-0274-01	
	Credit Card: Name on Card:	Account #:	Exp. Date:
	Form of Business:  Hospital Private Practice Processes	IS (340B) Sub PHS (340B Prime Vendor)	☐ FSS (DoD, VA, IHS)
	☐ Planned Parenthood ☐ Other (plea	se specify):	
	Tax Identification Number: FEIN:	SSN:	(If FEIN not available)
	Submit copy of tax exempt of	ertincate if eligible	(IT FEIN not available)
	•		rates quoted at the point-of-sale. Provider is financially responsible be due and payable by Provider within the payment terms offered
	Signature:	Print Name and Title:	Date:
	If different from signature, provide the name of the IMPLANO	N and/or NEXPLANON trained clinician responsib	ble for this order:
	NOTE: To order NEXPLANON NEXPLANON-specific	training is required. To order IMPLANOL	N IMPLANON-specific training is required

The information provided in response to your request for insurance coverage assistance will be based on statements of individuals not affiliated with Caremark, L.L.C or Schering  $Corporation \, (Merck), a \, subsidiary \, of \, Merck \, \& \, Co., \, Inc. \, \, Neither \, Merck \, nor \, Caremark, \, L.L.C. \, \, make \, any \, warranties, \, expressed \, or \, implied, \, about \, the \, accuracy \, of \, this \, information. \, \, Insurance \, and \, contains a containing of the expression of the expr$  $coverage\ status\ can \ change\ over\ time\ based\ on\ a\ variety\ of\ factors\ including,\ processing\ of\ additional\ claims\ that\ impact\ deductibles\ and/or\ coverage\ limits,\ changes\ in\ benefit\ design\ and\ or\ coverage\ limits,\ changes\ in\ coverage\ limits,\ changes\ limits,\ changes\ limits,\ changes\ limits,\ changes\ limits,\ changes\ limits,\ limits$ a patient's change in insurance carrier. The coverage information to be provided is intended for your reference only and does not guarantee current or future coverage for IMPLANON or NEXPLANON.

Individual patient coverage reports will be made available to the extent that information is made available by the insurance plan. The goal is to respond to your request in one to two  $business\ days.\ This\ timing\ cannot\ be\ guaranteed\ based\ on\ the\ willingness\ of\ insurance\ companies\ to\ release\ insurance\ coverage\ information.$ 

Fax to: 866-769-3882



### **Important Instructions**

When completing/submitting your 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. You may also order at www.cvs-implanondirect.com.



		t Service Request :: 866 318 3492 Fax: 866 769 3	1882 (eton	PLANON" ogestrel implant) a og Broefel		
Requested Services	Product: ☐ NEXPLANON ☐ IMPLANON Services Requested: ☐ Benefit Verification	☐ Prescription Order ☐ Buy	and Bill Purchase			
Patient		First Name:	Mt.	ook	SSRc	
Information	Address: Phone	City: Alternative Phone:	State:	Primary L	Zip Code:	
Patient	Prescription Drug Card:		Medical Insurance:			
Insurance	Phone					
Information	PCN: Policy E: P	Group F	Pelicy #		Group #	
Spy and attach force and hash of transport	Name:		Name			
onlesdenicipile	Employee	SSE	Insiner		554:	
hyard	Relation to Patient:		Relation to Patient:			
	Patient has no insurance and/or does not want in	surance billed. Requests Self Pay op	tion: Single payment	3 3-month payment p	lan	
	Agent to the Contract of the Market and Mark					
	stimbursement sonices. Information and question not aware of patient specific relimbursement inform undentand/shet I may request a copy of this Author Patient signature:	ns related to the information provide nation and are not permitted to discr station once it has been signed.	ed in regard to this reques as such information with o	t should be referred dir untomers. I have read th	ctly to Caremark L.L.C. Merck persons	
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	seimburament sonices. Information and question not aware of patient specific neimburament inform understand that I may request a copy of this Author Patient signature: Signature of lingui representative (if applicable)	ns related to the information provide nation and are not permitted to discr station once it has been signed.	ed in regard to this reques as such information with o	t should be referred dir ustomen. I have read th	ctly to Ceremark L.L.C. Menck person is document or have had it explained to	
Prescriber	neirbusement sonicos. Informacion and question not asses di placin specific insistentement inform understand that I may request a copy of this Author Parient úgrature:  Signuture of liegal representative (if applicable)  Prescriber Name (Piris Lazi:	ns related to the information provide nation and are not permitted to discr station once it has been signed.	ed in regard to this reques as such information with o	t should be referred dir untomers. I have read th	ctly to Ceremark L.L.C. Menck person is document or have had it explained to	
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Information	simbunement smious, Momentain and quinced social assistance profice institutionament inform understand that in my request a copy of this Author Parises signature: Signature of Registrations of applicable! Prosciolar Marie (Pirst, Latri) Marie of Parisonal Marie of Parisonal Mar	in stated to the information provide uniform and are not permitted in disc. itselfor-once it has been signed.  Phone: Oty: State Medical License.	ed in regard to this requests such information with of the control of t	Trice: UMD UD  Face: Zgolation-State: Zg	etly to Caremath LLC. Ments person is document or have had it explained is   Description of the company of the	
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#### 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 if there is a financial responsibility due.

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

PATIENT AUTHORIZATION: Please have patient read, sign and date.

**PRESCRIBER:** The prescriber listed on the form must be trained in the insertion and removal of IMPLANON if prescribing IMPLANON, or NEXPLANON, if prescribing NEXPLANON.

#### Prescription Information

**NOTE:** To order IMPLANON and/or NEXPLANON 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 and/or NEXPLANON.

**NOTE:** If your patient will be paying by cash, you may use this form as a prescription. Please check the box of either single payment or 3 month payment plan under the "Insurance Information" portion of this form. Product will ship without patient contact if the patient has zero financial responsibility.

#### **3** Shipping Information

**NOTE:** It is important that all shipping information be completed prior to submitting this form. If you have a requested delivery date, please indicate in the space provided.

#### Buy and Bill Purchase

**NOTÉ:** To purchase IMPLANON and/or NEXPLANON for Buy and Bill, complete this section. This will allow IMPLANON Direct to ensure that IMPLANON and/or NEXPLANON is received on time. Purchaser must sign a letter of agreement with CVS Caremark prior to first shipment.

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

If this person is not trained on the product purchased, please identify the trained clinician responsible for the order.

#### 5 Faxing the Form

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

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WOMN-1012193-0000 09/11

# Before submitting, remember to....

- ☐ Indicate product requested
- ☐ Indicate services requested
- Fill in the patient's information, including Social Security Number; have patient sign
- Make sure the prescriber listed on the form is trained in inserting IMPLANON and/or NEXPLANON
- 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