PARAGARD® T380A
intrauterine copper contraceptive

WEB: PARAGARDbvsp.com
PHONE: 1-888-275-8596
FAX: 1-855-215-5315

Patient Referral Form

PARAGARD Benefits Verification℠ | PARAGARD Specialty Pharmacy℠ | PARAGARD Patient Direct™

Service Requested (check only those that apply)

☐ PARAGARD Benefits Verification℠ ☐ PARAGARD Specialty Pharmacy℠ ☐ PARAGARD Patient Direct™ (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 PROVIDER

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

☐ **Z30.430** Encounter for insertion of intrauterine contraceptive device ☐ **Other** Please specify: _____

How do you intend to obtain PARAGARD?

☐ **N/A**, PARAGARD Benefits Verification℠ Only ☐ PARAGARD Direct™ (Buy & Bill) ☐ PARAGARD Specialty Pharmacy℠ ☐ PARAGARD Patient Direct™ (Patient Self-Pay)

PARAGARD Specialty Pharmacy℠ NOTIFICATION: By submitting this prescription request form and checking the PARAGARD Specialty Pharmacy℠ 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 based on my research:

(Does not apply to the following: Alaska, Arkansas, California, Colorado, District of Columbia, Georgia, Hawaii, Idaho, Iowa, Kentucky, Maryland, Minnesota, North Carolina, New Mexico, Oregon, Tennessee, or Virginia)

℞ **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 are made in the sole discretion of the health plan administrators and insurers. Biologics, Inc. makes no assurance that any prescribed drug will be covered or reimbursed at any specific level under any patient's insurance plan, or that any specific pharmacy will provide the prescribed drug.

Prescriber Signature: _____ Date: _____

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

PAR-41328 January 2018
CooperSurgical

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Patient Authorization Form

PARAGARD Benefits Verification℠ | PARAGARD Specialty Pharmacy℠ | PARAGARD Patient Direct™

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 CooperSurgical, 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" program is operated by Biologics on behalf of CooperSurgical, Inc.

Authorized Purposes

I understand that the PARAGARD Program and Biologics will receive my health and personal information, which may include my name, address, patient insurance identification number, date of birth and other information necessary to obtain health insurance benefit verification 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 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 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 CooperSurgical, 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 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

_____

PAR-41328 January 2018
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