PARAGARD
intrauterine copper contraceptive

PARAGARD
Access Solutions

WEB: ParagardAccessSolutions.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)

Patient Information

First Name: _____
Last Name: _____
Middle Initial: _____
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: _____

ICD-10 Coding

Z30.430 ☐ Encounter for insertion of intrauterine contraceptive device

Other ☐ Please specify: _____

J code: J7300

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

Healthcare Provider Information

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

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

℞ 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: _____

PARAGARD® intrauterine copper contraceptive

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PHONE: 1-888-275-8596
FAX: 1-855-215-5315
EMAIL: tevawhas@biologicsinc.com

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 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 120 Weston Oaks Court, 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

_____