PARAGARD® T380A
intrauterine copper contraceptive

Patient Referral Form

Patient Benefits Verification and Specialty Pharmacy Prescription Request Form

Phone (888) 275-8596
Fax (855) 215-5315
www.TWHAccessSolutions.com

Patient Information

First Name _____

Last Name _____

Middle Initial _____

Date of Birth _____

Street Address _____

_____

City _____ State _____

Zip _____

Phone _____

Alternate Phone _____

Patient Scheduled Placement Date _____

Insurance Information

(please copy and attach front and back of medical and prescription drug card insurance with request)

Self Pay ❑ Patient does not want insurance billed

Primary Insurance Name _____

Phone Number _____

Subscriber Name _____

Subscriber ID _____

ICD-9 Coding

V25.11 ❑ Encounter for insertion of intrauterine contraceptive device

Other ❑ Please specify _____

J code: J7300

Group Number _____

Subscriber DOB _____

Employer Name _____

Healthcare Prescriber 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®?

❑ Prescriber office will buy and bill ❑ Prescriber office will use Specialty Pharmacy

SPECIALTY PHARMACY NOTIFICATION: By submitting this prescription request form and checking the Specialty Pharmacy box above, prescriber and patient are aware that Biologics, Inc. will ship upon verification of benefits and collection of applicable copay.

Rx PARAGARD® (intrauterine copper contraceptive) Prescriber must call Biologics at (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 _____

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www.TWHAccessSolutions.com
Biologics, Inc. C/O TWH Access Solutions
120 Weston Oaks Court
Cary, NC 27513

Patient Authorization Form

PARAGARD® (intrauterine copper contraceptive)

Fax: (855) 215-5315

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. This Authorization also authorizes Biologics to call me for an appointment reminder before my placement date. The Teva Women's Health Access Solutions program is the "Access Solutions Program" operated by Biologics on behalf of Teva Women's Health, Inc.

Authorized Purposes

I understand that the 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 copay, to bill the insurance company, to bill the applicable copay and to ship the unit to my healthcare provider and (3) to contact me by telephone to remind me about appointments and in furtherance of conducting benefits investigations.

By signing the following form, I understand:

1. Once my healthcare provider gives Biologics and the Access Solutions program information about me based on this Authorization, my medical and health information may be subject to redisclosure and no longer protected by federal privacy regulations.

   I further understand and agree that Biologics and the Access Solutions program may retain my medical and health information as disclosed under this Authorization after this authorization expires for purposes related to the appointment reminder call data.

   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 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 Access Solutions program at the address listed at the top of this Authorization. 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

_____

Dated

_____

Name of Patient or Personal Representative

_____

(If Applicable) Description of Personal Representative's Authority to Sign for Patient

PARAGARD® T380A intrauterine copper contraceptive

PAR-40229 February 2014