Paragard® T380A
intrauterine copper contraceptive

Paragard Benefits Verification℠

PHONE: 1-888-275-8596
FAX: 1-855-215-5315

Benefits Verification Request Form

PRESCRIBER INFORMATION

Prescriber Name: ____________________
State Lic #: ____________________
NPI #: __________ Specialty: __________
Facility Name: ____________________
Address: ____________________
City: ____________________
State: ____________________
Zip: ____________________

Ship To Address (Required): ____________________
City: __________ **State:** __________ **Zip:** __________
Prescriber's Phone: ____________________
Prescriber's Fax: ____________________

PREFERRED COMMUNICATION
Office Contact Name: ____________________
Direct Phone Number: ____________________
Direct Email Address: ____________________
Direct Fax: ____________________

PATIENT INFORMATION

Patient Name: ____________________
Address: ____________________
City: __________ State: __________
Zip: ____________________

Home Phone: ____________________
Cell Phone: ____________________
Date of Birth: ____________________
☐ See Attached Demographic Sheet

INSURANCE INFORMATION (Please attach copies of front & back of cards)

Primary	Secondary	Rx Card
Primary Insurance: ______	Secondary Insurance: ______	Rx Card (PRM): ______
City: ______ State: ______	City: ______ State: ______	PBM BIN: ______
Plan #: ______	Plan #: ______	City: ______ State: ______
Group #: ______	Group #: ______	Group #: ______
Phone #: ______	Phone #: ______	Phone #: ______
Subscriber Name (First/Last): ______	Subscriber Name (First/Last): ______	Subscriber Name (First/Last): ______
ID #: ______	ID #: ______	ID #: ______
Employer: ______	Employer: ______	Employer: ______

PRESCRIPTION INFORMATION

☐ **PAR T380A – QTY 1**/Paragard (intrauterine copper contraceptive) to be inserted one time by prescriber.

DIAGNOSTIC INFORMATION (ICD-10 Code)

☐ **Z30.430:** Encounter for insertion of intrauterine contraceptive device

☐ **Other:** Please Specify ____________________

If 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, as required by applicable state law.

I understand that my signature will be used as an approval allowing the Specialty Pharmacy to dispense Paragard. If I have a financial responsibility for obtaining Paragard, I understand that Biologics will contact me prior to the dispense.

Patient Signature: ____________________ **Date:** ____/____/____

Prescriber Signature: ____________________ **Date:** ____/____/____

For ARNP, NP, and PA, collaborative physician agreement is with: ____________________ **Date:** ____/____/____

If you have any questions, please call 1-888-275-8596.

IMPORTANT: 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.

Paragard® is a registered trademark, and Paragard Benefits Verification℠ is a service mark of CooperSurgical, Inc.

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C-US-PAR-000023 August 2020

CooperSurgical

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Patient Authorization for Benefits Verification

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 it's 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) the administration of CooperSurgical's Paragard Program; (2) to conduct benefit verification determining insurance reimbursement and coverage of Paragard; (3) to contact me to discuss any relevant co-pay; (4) bill the insurance company; (5) bill the applicable co-pay; (6) ship the unit to my healthcare provider; (7) to contact me by telephone in furtherance of conducting benefits verifications investigations and/or specialty pharmacy dispense; and (8) if I choose to self-pay for Paragard, 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, health plan and/or pharmacy that refers to (or with a copy of) this Authorization form, or to Biologics/the Paragard Program at 11800 Weston Parkway, Cary, NC 27513. I understand that if I revoke this Authorization, it will not affect prior disclosures made 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 Legal Personal Representative: ______________________ **Date:** ____/____/____

Name of Patient or Legal Personal Representative: ______________________________

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

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Please see Important Safety Information and Full Prescribing Information for Paragard at Paragard.com.

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