Paragard® T380A intrauterine copper contraceptive

Paragard Specialty Pharmacy℠

WEB: ParagardAccessCenter.com
PHONE: 1-877-PARAGARD

Specialty Pharmacy Request Form

Complete the form, then fax pages 1 and 2 to your chosen specialty pharmacy. Give page 3 to the patient.

SPECIALTY PHARMACY (Choose one)

Specialty Pharmacy	Fax	Phone	Hours of Operation
☐ Biologics by McKesson	1-855-215-5315	1-888-275-8596	Mon-Fri 9:00 AM - 6:00 PM ET
☐ City Drugs – A BioMatrix Specialty Pharmacy*†	1-212-988-4501	1-855-988-4500	Mon-Fri 9:00 AM - 7:00 PM ET Sat 9:00 AM - 3:00 PM ET
☐ CenterWell Pharmacy† (formerly Humana Pharmacy)	1-877-405-7940	1-800-486-2668	Mon-Fri 8:00 AM - 11:00 PM ET Sat 8:00 AM - 6:30 PM ET

*Includes TriCare East †Includes TriCare West

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Cell Phone: _____

Date of Birth: _____

☐ See Attached Demographic Sheet

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: _____

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

☐ N/A (Patient Self-Pay)

Primary Insurance: _____
City: _____ State: _____
Plan #: _____
Group #: _____
Phone #: _____
Subscriber Name (First/Last): _____
ID #: _____
Employer: _____

Secondary Insurance: _____
City: _____ State: _____
Plan #: _____
Group #: _____
Phone #: _____
Subscriber Name (First/Last): _____
ID #: _____
Employer: _____

Rx Card (PRM): _____
PBM BIN: _____
City: _____ State: _____
Group #: _____
Phone #: _____
Subscriber Name (First/Last): _____
ID #: _____
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 the selected specialty pharmacy will contact me prior to the dispense.

Patient Signature: _____ **Date:** ___/___/___

Prescriber Signature: _____ **Date:** ___/___/___

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

IMPORTANT: Prescriber gives the selected specialty pharmacy 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. The selected specialty pharmacy 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. The selected specialty pharmacy 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.

CooperSurgical®

Patient Authorization for Specialty Pharmacy

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 specialty pharmacy agents (and their affiliates, respective representatives, and agents) in furtherance of the below-stated authorized purposes.

Authorized Purposes

I understand that the selected specialty pharmacy 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 the selected specialty pharmacy 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 the selected specialty pharmacy 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 the selected specialty pharmacy. I understand that if I revoke this Authorization, it will not affect prior disclosures made to the selected specialty pharmacy and any use of such information by the selected specialty pharmacy 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:

_____

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

Dear Patient,

Your healthcare provider has ordered Paragard through the following specialty pharmacy. This specialty pharmacy may contact you regarding Paragard, or you may contact them directly if you have any questions.

Specialty Pharmacy	Phone Number
☐ Biologics by McKesson	1-888-275-8596
☐ City Drugs – A BioMatrix Specialty Pharmacy	1-855-988-4500
☐ CenterWell Pharmacy (formerly Humana Pharmacy)	1-800-486-2668

To learn more visit Paragard.com

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

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