LILETTA ACCESSCONNECT℠ PATIENT INFORMATION FORM

PO Box 66551 • St Louis, MO 63166-6551
Phone: 855-LILETTA (855.545.3882) • Fax: 844.410.9571
(Monday - Friday, 9 AM - 6 PM ET, except holidays)

1. PATIENT INFORMATION

NAME (First, MI, Last) ______________________ DOB (MM/DD/YYYY) ______________________

ADDRESS ______________________ CITY ______________________

STATE ________ ZIP CODE ______________ EMAIL ______________________

HOME PHONE ______________ CELL PHONE ______________ BEST TIME TO CONTACT ______________

2. INSURANCE INFORMATION [Please attach copies of both sides of patient's insurance card(s)]

Do you have insurance through (check all that apply):

☐ Private Insurance ☐ VA/Military ☐ State Assistance Program ☐ Medicaid ☐ CHECK IF PATIENT DOES NOT HAVE INSURANCE

Medicare: ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage ☐ Other

PRIMARY INSURANCE ______________________ INSURANCE PHONE # ______________________

POLICY ID # ______________ GROUP# ______________ POLICY HOLDER ______________

SECONDARY INSURANCE ______________________ INSURANCE PHONE # ______________________

POLICY ID # ______________ GROUP# ______________ POLICY HOLDER ______________

PHARMACY PLAN NAME ______________________ PBM PHONE # ______________________

POLICY ID # ______________ GROUP# ______________ RX BIN # ______________ RX PCN # ______________

3. PRESCRIBER INFORMATION

PRESCRIBER NAME (First, Last) ______________________ NPI # ______________________

PRACTICE NAME ______________________ OFFICE CONTACT ______________________

ADDRESS ______________________

CITY ______________________ STATE ______________ ZIP CODE ______________

E-MAIL ______________ HOME PHONE # ______________ CELL PHONE # ______________

TAX ID # ______________ BCBS # ______________ MEDICAID #/PIN ______________

STATE LICENSE # ______________ SPECIALTY ______________ MEDICARE PLAN ______________

4. CLINICAL INFORMATION

DIAGNOSIS ☐ Z30.430 ☐ OTHER ______________________

5. PHYSICIAN ATTESTATION

By signing this form, I certify that therapy with LILETTA is medically necessary for my patient. I will be supervising my patient's treatment accordingly and I have reviewed the current LILETTA prescribing information. I attest that I am acting on behalf of my patient and I have the necessary Health Insurance Portability and Accountability Act (HIPAA) authorization from my patient to release my patient's medical and/or other patient information relating to LILETTA therapy to United BioSource Corporation and its affiliates—the service provider engaged by Allergan, which will not receive any patient-identifiable information—to use and disclose as necessary to complete a benefits investigation for my patient in the LILETTA AccessConnect℠ Program.

PRODUCT: LILETTA **INSERTION DATE:** ______________________

Provider's Signature ______________________ **Date** ______________________

IMPORTANT WARNING

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LETTER OF MEDICAL NECESSITY TEMPLATE

If a patient's insurer requires prior authorization or if you receive a claim denial, please feel free to use this template for a Letter of Medical Necessity to the insurer. On your office letterhead, include the suggested items of information listed below to communicate why you believe LILETTA is in the best medical interest of the patient. The completeness of your Letter of Medical Necessity will be critical for consideration of the prior authorization/appeal.

A Letter of Medical Necessity typically includes:

- Patient name
- Member ID
- Initial date of diagnosis
- Prior treatments given
- For prior treatment given, list all drugs, dosages, schedules, clinical response, and reason for discontinuation
- Specific reason why LILETTA is in the best medical interest of the patient

If you have any questions, please call LILETTA AccessConnect℠ at 855-LILETTA (855.545.3882), Option 3. Representatives are available Monday through Friday from 9:00 AM to 6:00 PM ET (except holidays) to assist you.

Note: The information provided in connection with a LILETTA AccessConnect℠ Benefits Investigation is for informational purposes only and should not replace a review of benefits by the physician to determine coverage and reimbursement. Coverage, coding, and reimbursement will vary by payer, plan, patient, professional setting, and services rendered, and are all subject to change without notice. Actual coverage and reimbursement decisions are made by individual payers following receipt of claims.

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