Liletta® (levonorgestrel-releasing intrauterine system) 52 mg

PRESCRIPTION & ENROLLMENT FORM

accredo® CVS specialty™

FIVE SIMPLE STEPS TO SUBMIT YOUR REFERRAL

All fields must be completed to facilitate prescription fulfillment

1. SELECT CHOICE OF SPECIALTY PHARMACIES

Specialty Pharmacy	Fax Number	Phone Number	Hours of Operation
☐ Accredo	1.888.355.6682	1.866.759.1557	8:00 AM – 7:00 PM ET
☐ CVS Caremark	1.844.802.1416	1.855.438.2574	8:30 AM – 8:30 PM ET

2. PATIENT INFORMATION

☐ New patient ☐ Current patient

Patient's name _____ Date of birth _____
Last 4 digits of SSN _____ ☐ Female
Street address _____ Apt # _____
City _____ State _____ ZIP code _____
Parent/guardian (if applicable) _____
Home phone _____ Primary phone _____
Cell phone _____ Alternate phone _____
Email address _____
Patient's primary language: ☐ English ☐ Other If other, please specify _____

I understand that when my healthcare provider submits my LILETTA Specialty Pharmacy prescription request and enrollment form, the specialty pharmacy will: 1) verify my benefits; 2) collect any copay; 3) ship out my prescription to my healthcare provider. I understand that if I do not sign this form, none of my information will be shared and I may be contacted by the specialty pharmacy, as the request and enrollment cannot be fulfilled without my consent.

☐ I consent to the terms above.

Privacy Notice: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, visit https://abbv.ie/PrivacyPatient.

Consent to process my sensitive personal information: Through my submission of the LILETTA Prescription & Enrollment form, I consent to the collection, use, and disclosure of my personal health data, as described in the Privacy Notice above and in AbbVie's Privacy Notice in the "How We May Disclose Personal Data" section. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "Your Privacy Choices" on AbbVie's website.

Patient signature _____ Date _____
Parent/guardian signature (if applicable) _____ Date _____

3. CLINICAL INFORMATION

Primary ICD-10 code _____
Other (list ICD-10 code) _____
Date of last menses _____
☐ NKDA ☐ Known drug allergies _____
Concurrent meds _____
Requested date of delivery _____ Scheduled insertion date _____

4. PRESCRIBER INFORMATION

Date _____ Time _____
Prescriber's name and title _____
If NP or PA, under direction of Dr. _____
Office contact _____ Office contact direct phone _____
Clinic/hospital affiliation _____
Street address _____ Suite # _____
City _____ State _____ ZIP code _____
Phone _____ Fax _____
NPI # _____ License # _____
Deliver product to ☐ Office ☐ Clinic Clinic location _____

Privacy Notice for Health Care Provider: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, visit https://abbv.ie/PrivacyHCP.

5. PRESCRIPTION INFORMATION

Medication	Strength/ Formulation	ICD-10	J-Code	NDC	Directions	Quantity
LILETTA (levonorgestrel-releasing intrauterine system)	☐ 52 mg	Z30.014	J7297	0023-5858-01	To be inserted intrauterinely by a healthcare provider	1

When shipped to physician's office, physician accepts on behalf of patient for administration in office.
By signing below, I certify that the above therapy is medically necessary.
Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

Signature _____ Date _____

"Dispense As Written"/Brand Medically Necessary/Do Not Substitute/No Substitution/DAW/May Not Substitute
Prescriber's Signature: _____
Date: _____

May Substitute/Product Selection Permitted/Substitution Permissible
Prescriber's Signature: _____
Date: _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. **CA, MA, NC & PR:** Interchange is mandated unless Prescriber writes the words "No Substitution"
ATTN: New York and Iowa providers, please submit electronic prescription

PATIENT INSURANCE INFORMATION (Please copy and attach the front and back of medical and prescription insurance cards – Send with request)

Patient has no insurance and/or does not want insurance billed. ☐ Request self-pay option

Prescription Insurance: _____
Phone: _____
ID #: _____ Group #: _____
Policy Holder Information (if different from patient)
Name: _____ Employer: _____
Relation to Patient: _____

Medical Insurance: _____
Phone: _____
ID #: _____ Group #: _____
Policy Holder Information (if different from patient)
Name: _____ Employer: _____
Relation to Patient: _____

This form is for patient-specific orders dispensed through a specialty pharmacy. Please contact 1-855-LILETTA (1.855.545.3882) to place a buy and bill order for office stock.

PLEASE FAX THE COMPLETED PRESCRIPTION REQUEST FORM, INCLUDING THE SIGNED AUTHORIZATION SECTION ON PAGE 2, TO: Accredo **1.888.355.6682** CVS Caremark **1.844.802.1416**

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PRESCRIPTION & ENROLLMENT FORM

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

LILETTA® Specialty Pharmacy Program

I authorize my healthcare providers and staff, health plan, and pharmacies (collectively, my "Healthcare Providers") to disclose individually identifiable information about me, my health or condition(s), treatment and care that I have received, my insurance coverage, my payment information, and my medication history and prescriptions (collectively, "Protected Health Information") to AbbVie Inc. and/or its designated affiliates, agents, representatives, and service providers (collectively, "AbbVie") in order for AbbVie to (i) enroll me in, provide, operate and administer the **LILETTA Specialty Pharmacy Program** ("Program"); (ii) provide me with information concerning the Program; and (iii) develop, evaluate, and improve products, services, materials, and programs related to my condition or treatment. I understand that Protected Health Information disclosed to AbbVie under this Authorization will no longer be protected by HIPAA and may be subject to redisclosure by AbbVie. I understand that my Healthcare Provider may use my Protected Health Information to identify and provide information about products and services that may be of interest to me based on my participation in the Program. I understand that I am not required to sign this Authorization and that my Healthcare Providers will not otherwise condition my treatment, payment, health insurance enrollment, or eligibility for healthcare benefits to which I am otherwise entitled on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I cannot take part in the Program. I understand that this Authorization will expire once I am no longer participating in the Program, unless I cancel it sooner. I understand that I may cancel this Authorization at any time by making a data subject rights request at https://abbviemetadata.my.site.com/AbbvieDSRM or by writing to privacydsr@abbvie.com. However, I understand that if I cancel this Authorization, it will end my enrollment in the Program. I understand that cancelling this Authorization will not affect any use or disclosure of my Protected Health Information that has already taken place in reliance on this Authorization.

My signature below certifies that I have read, understood, and agree to the release of my Protected Health Information pursuant to this Authorization. I verify the information provided is true and correct. If I am the caregiver/representative of the patient, I confirm I am authorized to sign on behalf of the patient.

Patient Name: _____

Patient Signature: _____

Date: _____

Caregiver / Representative Name (if applicable):

_____

Note: You have a right to receive a copy of this Authorization. You may print a copy of or save this Authorization and retain a copy for your records

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