LILETTA® (levonorgestrel-releasing intrauterine system) 52 mg
REPLACEMENT REQUEST FORM (RRF)

Please provide the following information for ALL requests: Failure to complete this form in full may result in a delay in processing or a denial of the replacement request.

Tracking ID: _____

Date of request: _____

Contact name: _____ Contact title: _____

Contact email address: _____ Phone number: _____

Healthcare facility name: _____

Healthcare facility street address: _____ City, State, ZIP: _____

Healthcare facility LILETTA ship-to account number: _____

Healthcare practitioner name: _____

Healthcare practitioner NPI #: _____ DEA #: _____

Return unit information: LILETTA Lot #: ☐☐☐☐☐-☐☐ Expiration date: _____

Patient initials: _____ Patient DOB: _____

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, if you are a patient visit *https://abbv.ie/PrivacyPatient*, if you are a prescriber visit *https://abbv.ie/PrivacyHCP*. **If you are a prescriber, please share this information with your patient.**

Replacement Request Form must be submitted within thirty (30) days of drop/contamination, incomplete insertion, or expulsion/removal.

Please indicate the ONE reason for the replacement request and carefully review the policies and procedures associated with the request:

1. ☐ Request to replace product that was **accidentally dropped or contaminated pre-insertion** within thirty (30) days of drop or contamination:

- Complete, scan, and **email the RRF to LilettaSupport@abbvie.com**. A return authorization number ("RA#"), prepaid shipping label, and **instructions on how to return the product** will be provided within three (3) to five (5) business days.

Your replacement request will be evaluated by AbbVie. If AbbVie determines (in its sole discretion) that a replacement is appropriate, a replacement unit will be issued within approximately ten (10) business days.

2. ☐ Request to replace product that is contaminated due to **an incomplete insertion** procedure within thirty (30) days of incomplete insertion:

- Complete, scan, and **email the RRF to Liletta_Intake@abbvie.com**. If you wish to speak to a representative about the incomplete insertion, please contact AbbVie Product Quality Complaints at 1-800-678-1605.

Your replacement request will be evaluated upon receipt of a signed, complete RRF. If, after internal processing, AbbVie determines (in its sole discretion) that a replacement is appropriate, a replacement unit will be issued within approximately ten (10) business days.

3. ☐ Request to replace product due to **product quality complaint** in which a physical or mechanical defect in the product, its packaging, or the labeling is suspected.

- Complete, scan, and **email the RRF to Liletta_Intake@abbvie.com**. If you wish to speak to a representative about the product quality, please contact AbbVie Product Quality Complaints at 1-800-678-1605.

Your replacement request will be evaluated upon receipt of a signed, complete RRF. If, after internal processing, AbbVie determines (in its sole discretion) that a replacement is appropriate, a replacement unit will be issued within approximately ten (10) business days.

4. ☐ Request to replace product that is **accidentally expelled or removed** within thirty (30) days after expulsion or removal:

- Complete, scan, and **email the RRF to usaeagn@abbvie.com**. If you wish to speak to a representative about the expulsion or removal, please contact AbbVie Safety at 1-800-678-1605.

Your replacement request will be evaluated upon receipt of a signed, complete RRF. If, after internal processing, AbbVie determines (in its sole discretion) that a replacement is appropriate, a new unit will be provided to the requesting healthcare practitioner for the one that was expelled/removed from the patient listed on the RRF form within approximately ten (10) business days. An expelled or removed unit will not be requested for return.

Please provide a detailed description of and reason for the event leading to this request:

_____

_____

Date of insertion: _____ **Date of event:** _____ **Was patient contact made with the unit?** ☐ Yes ☐ No

Was the unit placed? ☐ Yes ☐ No **Were the threads cut?** ☐ Yes ☐ No

If yes to both, would you describe the event as: ☐ partial expulsion *or* ☐ complete expulsion *or* ☐ medical event requiring removal

Is the unit available for return? ☐ Yes ☐ No

I further certify that the information provided in this form is complete and accurate to the best of my knowledge and I agree to notify AbbVie of any changes I become aware of that could affect the evaluation or consideration of this replacement request.

Required Signatures:

Healthcare practitioner signature: _____

Healthcare practitioner name (Print): _____

For Expelled or Removed Units ONLY, patient acknowledgment of this replacement request is required:

Patient acknowledgment – Initials only: _____

ALL INFORMATION ON THIS FORM IS REQUIRED UNLESS OTHERWISE STATED, INCLUDING THE HEALTHCARE PRACTITIONER SIGNATURE. FAILURE TO COMPLETE THE FORM IN FULL MAY RESULT IN A DELAY IN PROCESSING OR A DENIAL OF THE REPLACEMENT REQUEST.