Liletta (levonorgestrel-releasing intrauterine system) 52 mg | ACCESS CONNECT℠

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 _____

EMAIL _____

OFFICE PHONE # _____ OFFICE FAX # _____ 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 AbbVie, 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** _____

US-LLT-220221 01/23

LILETTA ACCESSCONNECT℠
PO Box 66551 • St Louis, MO 63166-6551
Phone: 855-LILETTA (855.545.3882)
Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	1
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

NEW PATIENT INFORMATION

Dear Dr < Prescriber First Name Last Name>,

Thank you for submitting a completed **LILETTA AccessConnect℠** Patient Information Form. Below you will find your patient's LILETTA AccessConnect℠ identification number. Please include this information in your patient's chart as confirmation that you submitted their information to LILETTA AccessConnect℠. You will need this information when contacting the Program for any questions you have or for any support needed.

We will be contacting your patient's insurance to investigate coverage for **LILETTA** and to identify prior authorization requirements as applicable. Once coverage is established, we will notify you of next steps.

Patient Name: <insert patient name>
LILETTA AccessConnect ID: <insert ID#>

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.

Sincerely,

LILETTA AccessConnect℠

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.

US-LLT-220221 01/23

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Phone: 855-LILETTA (855.545.3882)
Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	1
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

MISSING BENEFITS INVESTIGATION INFORMATION REQUEST

Dear Dr <Prescriber First Last Name>,

Thank you for your interest in **LILETTA AccessConnect℠** for the patient listed above. In order to complete your patient's benefits investigation, we are in need of the following additional information:

- ☐ Prescriber's name is missing or illegible
- ☐ Prescriber's address is missing or illegible
- ☐ Prescriber's signature is missing
- ☐ Patient's name is missing or illegible
- ☐ Patient's address is missing or illegible
- ☐ Patient's phone # is missing or illegible
- ☐ Patient's phone # has been disconnected. Please provide alternative number
- ☐ Patient's date of birth is missing or illegible
- ☐ Patient's insurance information is missing or illegible
- ☐ Other:

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.

Sincerely,

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FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	1
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

CASE INACTIVATION DUE TO MISSING INFORMATION

Dear Dr < Prescriber First Name Last Name>,

Thank you for your interest in **LILETTA AccessConnect℠** for the patient listed above. Unfortunately, we are still unable to complete your patient's benefits investigation for the following reasons:

- ☐ Prescriber's name is missing or illegible
- ☐ Prescriber's address is missing or illegible
- ☐ Prescriber's signature is missing
- ☐ Patient's name is missing or illegible
- ☐ Patient's address is missing or illegible
- ☐ Patient's phone # is missing or illegible
- ☐ Patient's phone # has been disconnected. Please provide alternative number
- ☐ Patient's date of birth is missing or illegible
- ☐ Patient's insurance information is missing or illegible
- ☐ Patient's prior authorization was not submitted to the payer
- ☐ Patient's appeal was not submitted to the payer
- ☐ Other:

Please contact us at 855-LILETTA (855.545.3882), Option 3 as soon as possible with the missing information or fax an updated Patient Information Form to 844.410.9571. We have been unsuccessful in reaching you and gathering the information needed to complete the patient's benefits investigation. Further action cannot be taken until you contact us. Your patient's case will remain inactive until completed information is received.

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.

Sincerely,

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Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

Dear Dr <Prescriber Name>,

Thank you for choosing **LILETTA AccessConnect℠**.

We were not able to verify that your patient had coverage for **LILETTA**. Your patient may be eligible for myAbbvie Assist, the AbbVie patient assistance program. For more information, please visit AbbVie.com /myAbbVieAssist or contact the program at 1-800-222-6885 for assistance.

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.

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Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

Dear Dr <Prescriber Name>,

Thank you for choosing **LILETTA AccessConnect℠**.

We were not able to verify that your patient had coverage for **LILETTA**. Your patient may be eligible for myAbbvie Assist, the AbbVie patient assistance program. For more information, please visit AbbVie.com /myAbbVieAssist or contact the program at 1-800-222-6885 for assistance.

As part of our process, we use information provided on the patient information form to determine if your patient may qualify for programs that can provide coverage for all your patient's medications, not just LILETTA. **Based on information provided on the patient information form, it appears that your patient may be eligible for coverage from the following program(s):**

<Alternate Fund/Coverage
Phone Number Website>

Please encourage your patient to apply directly to this coverage option. We are available to assist you and your patient in any way we can.

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.

Sincerely,

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FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

Dear Dr <Prescriber Name>,

Thank you for choosing **LILETTA AccessConnect℠**.

Please see the attached Patient Benefit Summary Report for the above listed patient's **LILETTA** therapy.

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.

Sincerely,

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Phone: 855-LILETTA (855.545.3882)
Fax: 844.410.9571

Patient Benefit Summary

Patient Information

Patient name: <First Last>	Patient ID: <UBC-xx-xxxxx-xxxxx>
Patient date of birth: <xx/xx/xxxx>	Provider name: <Prescriber Name>

Summary of Benefits

	Pharmacy Benefit	**Medical Benefit**
Health insurance	<payer>	<payer>
Plan phone #	<xxx.xxx.xxxx>	<xxx.xxx.xxxx>
Policy #	<policy #>	<policy #>
Group #	<group #>	<group #>
Contracted specialty pharmacy(ies)	<Specialty pharmacy(ies)>	
Benefit Details		
Deductible	<$0.00>	<$0.00>
Deductible met	<$0.00>	<$0.00>
Copay/coinsurance	<$0.00>/<%>	<$0.00>/<%>
Out of pocket	<$0.00>	<$0.00>
Out of pocket met	<$0.00>	<$0.00>
Spend down	<$0.00>	<$0.00>
Additional information:		

THIS SUMMARY OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. Verbal verifications provided by insurers cannot take the place of written policy information, Explanation of Benefits (EOB) statement, or paid claims.

IMPORTANT NOTE

LILETTA AccessConnect℠ provides information about patient insurance benefits, including copay and coinsurance, for LILETTA. Information about other medications and treatments, including IUDs from other manufacturers, is not provided. The information provided by this service is for the benefit of the patient to understand possible insurance benefits. The information from LILETTA AccessConnect℠ is for informational purposes only and should not replace a review of benefits by the healthcare provider to determine coverage and reimbursement. Healthcare providers must follow the practices and procedure required by third-party payers when submitting claims for payment. The information available through LILETTA AccessConnect℠ is obtained directly from participating third-party payers providing primary health insurance coverage, not secondary health insurance coverage. Provision of information by participating third-party payers does not constitute an endorsement by the payer of LILETTA AccessConnect℠. Neither AbbVie nor United BioSource Corporation (UBC) guarantees or provides any warranties regarding the information provided, nor of the coverage, coding, or reimbursement of LILETTA or administration fees for insertions. 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. LILETTA AccessConnect℠ does not adjudicate or otherwise submit claims to third-party payers.

There is no obligation upon the healthcare provider or the patient that the patient be administered an AbbVie product after a benefits investigation is performed. The healthcare provider is responsible to determine whether a product is indicated for and consistent with the medical needs of each patient; eligibility for reimbursement by a particular payer is not a representation that the product is appropriate for that patient. Benefits investigation results for a patient will not result in entries or revisions to the medical records of the patient, nor will it result in entries to third-party payer claims-made or claims-paid records. Information about reimbursement eligibility submitted through LILETTA AccessConnect℠ is not a requirement for submission of claims to third-party payers. No patient information will be provided to AbbVie by UBC, the service provider engaged by AbbVie to operate the services offered through LILETTA AccessConnect℠.

IMPORTANT WARNING

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LILETTA ACCESSCONNECT℠
PO Box 66551 • St Louis, MO 63166-6551
Phone: 855-LILETTA (855.545.3882)
Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

Dear Dr <Prescriber Name>,

Thank you for choosing **LILETTA AccessConnect℠**.

Please see the attached Patient Benefit Summary Report for the above listed patient's **LILETTA** therapy.

It appears that your patient might be eligible for the LILETTA Patient Savings Program®* where your patient may receive assistance with out-of-pocket costs greater than $100, up to a maximum savings limit of $750. Please give your patient a LILETTA Patient Savings Program® brochure and tell her to visit www.LILETTAcard.com or call 855.706.4508 for assistance.

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.

Sincerely,

LILETTA AccessConnect℠

*Depending on insurance coverage, eligible patients pay $100, then save up to a maximum of $750 for the LILETTA® product. Offer applies to product only, and does not apply to costs associated with medical examination or product administration. Check with your pharmacist or healthcare provider for your copay discount. Patient out-of-pocket expense may vary. Offer not valid for patients enrolled in Medicare, Medicaid, or other federal or state healthcare programs. **Please see full LILETTA Patient Savings Program® Terms, Conditions, and Eligibility Criteria at LILETTA.com.**

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Phone: 855-LILETTA (855.545.3882)
Fax: 844.410.9571

Patient Benefit Summary

Patient Information

Patient name: <First Last>	Patient ID: <UBC-xx-xxxxx-xxxxx>
Patient date of birth: <xx/xx/xxxx>	Provider name: <Prescriber Name>

Summary of Benefits

	Pharmacy Benefit	Medical Benefit
Health insurance	<payer>	<payer>
Plan phone #	<xxx.xxx.xxxx>	<xxx.xxx.xxxx>
Policy #	<policy #>	<policy #>
Group #	<group #>	<group #>
Contracted specialty pharmacy(ies)	<Specialty pharmacy(ies)>	
Benefit Details		
Deductible	<$0.00>	<$0.00>
Deductible met	<$0.00>	<$0.00>
Copay/coinsurance	<$0.00>/<%>	<$0.00>/<%>
Out of pocket	<$0.00>	<$0.00>
Out of pocket met	<$0.00>	<$0.00>
Spend down	<$0.00>	<$0.00>
Additional information:		

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IMPORTANT NOTE

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There is no obligation upon the healthcare provider or the patient that the patient be administered an AbbVie product after a benefits investigation is performed. The healthcare provider is responsible to determine whether a product is indicated for and consistent with the medical needs of each patient; eligibility for reimbursement by a particular payer is not a representation that the product is appropriate for that patient. Benefits investigation results for a patient will not result in entries or revisions to the medical records of the patient, nor will it result in entries to third-party payer claims-made or claims-paid records. Information about reimbursement eligibility submitted through LILETTA AccessConnect℠ is not a requirement for submission of claims to third-party payers. No patient information will be provided to AbbVie by UBC, the service provider engaged by AbbVie to operate the services offered through LILETTA AccessConnect℠.

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Phone: 855-LILETTA (855.545.3882)
Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

Dear Dr <Prescriber Name>,

Thank you for choosing **LILETTA AccessConnect℠**.

Please see the attached Patient Benefit Summary Report for the above listed patient's **LILETTA** therapy.

Please be aware that additional third party assistance may be available to help with the costs of your patient's healthcare. Subject to availability of funds and individual program criteria, your patient may be eligible for additional assistance with coinsurance, premium, and/or deductible as well as other sources of assistance. **Based on information provided on the patient information form, it appears that your patient may be eligible for additional assistance from the following program(s):**

<Alternate Fund/Coverage
Phone Number Website>

Please encourage your patient to apply directly to this coverage option. We are available to assist you and your patient in any way we can.

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.

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Patient Benefit Summary

Patient Information

Patient name: <First Last>	Patient ID: <UBC-xx-xxxxx-xxxxx>
Patient date of birth: <xx/xx/xxxx>	Provider name: <Prescriber Name>

Summary of Benefits

	Pharmacy Benefit	Medical Benefit
Health insurance	<payer>	<payer>
Plan phone #	<xxx.xxx.xxxx>	<xxx.xxx.xxxx>
Policy #	<policy #>	<policy #>
Group #	<group #>	<group #>
Contracted specialty pharmacy(ies)	<Specialty pharmacy(ies)>	
Benefit Details		
Deductible	<$0.00>	<$0.00>
Deductible met	<$0.00>	<$0.00>
Copay/coinsurance	<$0.00>/<%>	<$0.00>/<%>
Out of pocket	<$0.00>	<$0.00>
Out of pocket met	<$0.00>	<$0.00>
Spend down	<$0.00>	<$0.00>
Additional information:		

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Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	3
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

DENIAL / UNDER-REIMBURSEMENT APPEAL INFORMATION

Dear Dr <Prescriber First Last Name>,

Enclosed is a template letter that you may choose to use when submitting your written appeal of the recent <DENIAL/UNDER-REIMBURSEMENT> of a LILETTA claim prescribed to the patient listed above. This message was generated in response to a claim that you had acquired LILETTA that was later reimbursed by a commercial or government payer at less than the net acquisition cost, or not at all. The 'net acquisition cost' is the cost for the unit including any volume and/or contracted discounts. 'Reimbursement' refers to the total provider reimbursement, including any patient cost share.

Submission of this letter does not guarantee the request will be granted by the insurer. Please edit the letter as needed and replace **[bold]** sections and the 'Example' section with the appropriate information.

The letter should be written on your/the clinic's letterhead and include information on how to contact you.

We recommend that you consider the following when completing the letter for your patient. Include the patient's information as requested:

- Name
- Date of birth
- Medical insurance member ID number
- Insurance claim reference number
- Net acquisition cost documentation for specific unit (ie, product invoice)

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.

US-LLT-220221 01/23

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Phone: 855-LILETTA (855.545.3882)
Fax: 844.410.9571

Include criteria documentation:

- Documented diagnosis
- Any contraindications with medication preferred by insurance provider

You may also submit additional documentation that supports the clinical decision to utilize LILETTA:

- Most recent chart notes
- Additional clinical information
- Journal or peer-reviewed articles

Finally, we recommend including any additional information you feel would be useful to support your decision to prescribe LILETTA and need to be reimbursed equivalent to the net acquisition cost.

The appeal can be submitted in the following way(s): <only display options that apply>

Fax: <insert fax number> <check if appeal can be completed by fax>

Online: <insert URL> <check if appeal can be completed online>

Mail: <insert address> <check if appeal can be completed by mail>

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.

Sincerely,

LILETTA AccessConnect℠

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DENIAL / UNDER-REIMBURSEMENT APPEAL Letter Template
[Office Letterhead]

[Date]
[Insurance company]
[Insurance company address]
[Insurance company phone/fax]

Re: **[Patient name, DOB]**
[Member ID]
[Claim #]

To Whom It May Concern:

This is a **[denial / under-reimbursement]** appeal request for the LILETTA prescribed to **[patient name]**.

The qualifying medical history that necessitates the use of LILETTA for **[patient name]** includes:

1. **Diagnosis:**
2. **Clinical symptoms, including: [list patient symptoms]**
3. **Reason for prescribing LILETTA: [initiation of therapy, clinical worsening, combination therapy, failed previous therapy]**
4. **[additional information as needed]**

Claim for the reimbursement of LILETTA was submitted due to the aforementioned medical necessity and contraceptive mandate included in the Affordable Care Act. This mandate states that all health insurance providers included in the Health Insurance Marketplace must cover implanted contraceptive devices (eg, intrauterine systems).

As shown in the included billing documentation, our practice was **[denied reimbursement / received under-reimbursement]** for LILETTA. For reference, the current Wholesale Acquisition Cost (WAC) for LILETTA is **[WAC]**. We would like to submit this appeal to receive reimbursement equivalent to the acquisition cost for this medically necessary device.

If you require additional information, please contact **[contact information]**.

Thank you for your consideration.
Sincerely,
[Signature]
[date]
[Print name]
[Address]
[Phone number] [Fax number]

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Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

PRIOR AUTHORIZATION REQUEST

Dear Dr <Prescriber First Last Name>,

Coverage may be available following a prior authorization. We are unable to submit a request for prior authorization because the insurance company requires some additional medical documents.

Documentation required

☐ Attached Prior Authorization Form

☐ Letter of Medical Necessity

☐ Diagnosis

<Additional Prior Authorization requirements/information>

Please fax the requested information to <enter insurance contact> at fax #: <xxx.xxx.xxxx>.

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.

Sincerely,

LILETTA AccessConnect℠

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Liletta (levonorgestrel-releasing intrauterine system) 52 mg | ACCESS CONNECT℠

Important Information Regarding Pennsylvania Medicaid Authorization

Medicaid of Pennsylvania requires prior authorization to be conducted over the phone. This can be done by calling the Pennsylvania Dept of Public Welfare at 800.537.8862. Listed below is the type of information that will likely be needed.

1. HEALTH PLAN INFORMATION

NAME: Pennsylvania Department of Public Welfare PHONE NUMBER: 800.537.8862

2. PATIENT INFORMATION

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

ADDRESS _____ CITY_____

STATE _____ZIP CODE _____HOME PHONE_____ CELL PHONE _____

ICD 9 or 10 CODE: _____DIAGNOSIS _____SEX: ☐ Male ☐ Female

3. INSURANCE INFORMATION

DOES THE PATIENT HAVE MEDICARE? ☐ Yes ☐ No LONG-TERM CARE RESIDENT? ☐ Yes ☐ No

PHARMACY PLAN NAME_____

PHONE NUMBER_____FAX NUMBER _____

4. PRESCRIBER INFORMATION

PRESCRIBER NAME (First, Last)_____ NPI # _____

ADDRESS _____

CITY _____STATE_____ ZIP CODE_____

PHONE_____FAX _____ SPECIALTY _____

5. PRESCRIPTION INFORMATION

DRUG NAME: LILETTA (levonorgestrel-releasing intrauterine system) 52 mg DOSAGE: 20.4 mcg/day

6. PREVIOUS DRUG HISTORY PERTINENT TO THIS REQUEST

DRUG 1 NAME: _____DOSAGE: _____ OUTCOME: _____

DRUG 2 NAME: _____DOSAGE: _____ OUTCOME: _____

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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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Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

PRIOR AUTHORIZATION DENIAL

Dear Dr <Prescriber First Name Last Name>,

LILETTA AccessConnect℠ has been informed that the prior authorization for the patient listed above has been denied by <insert insurance company name>.

An appeal may be available for your patient. If you would like assistance with the appeals process, please call LILETTA AccessConnect℠ at 855-LILETTA (855.545.3882), Option 3.

Prescriber Next Steps

- ✓Prescriber initiate appeal directly to the payer; or
- ✓Request assistance from LILETTA AccessConnect℠ with:
  - Researching the appeals process with the patient's plan
  - Providing you with the appeal criteria
  - Providing appeal template letter
  - Following up with the payer for appeal outcome

Sample documentation that may be required:

- Denial letter
- Letter of Medical Necessity
- Any updated office visit notes and test results
- Other: <insert other documents>

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Sincerely,

LILETTA AccessConnect℠

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FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	3
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

APPEAL/PRIOR AUTHORIZATION INFORMATION

Dear Dr <Prescriber First Last Name>,

Enclosed is a template letter you may choose to use when submitting your written appeal of the recent <prior authorization denial><denied claim> of **LILETTA** for the patient listed above.

Submission of this letter does not guarantee the request will be granted by the insurer. Please edit the letter as needed and replace **[bold]** sections and the Example section with the appropriate information.

The letter should be written on your/the clinic's letterhead and include information on how to contact the physician.

We recommend that you consider the following when completing the letter for your patient.

Include the patient's information as requested:

- Name
- Date of birth
- Prescription insurance member ID number
- <PA reference number> <claim denial reference number>

Include criteria documentation:

- Documented diagnosis
- Any contraindications with medication preferred by insurance provider

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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Fax: 844.410.9571

You may also submit additional documentation that supports the clinical decision to utilize LILETTA:

- Most recent chart notes
- Additional clinical information
- Journal or peer-reviewed articles

Finally, include any additional information you feel would be useful to support your decision to prescribe LILETTA.

The appeal can be submitted in the following way(s): <only display options that apply>

Fax: <insert fax number> <check if appeal can be completed by fax>

Online: <insert URL> <check if appeal can be completed online>

Mail: <insert address> <check if appeal can be completed by mail>

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.

Sincerely,

LILETTA AccessConnect℠

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APPEAL/PRIOR AUTHORIZATION LETTER TEMPLATE
[Office Letterhead]

[Date]
[Insurance company]
[Insurance company address]
[Insurance company phone/fax]

Re: **[Patient name, DOB]**
[Member ID]

To Whom It May Concern:

This is a **[prior authorization request]** / **[appeal in response to coverage denial]** for LILETTA for **[patient name]**.

The qualifying medical history that necessitates the use of LILETTA for **[patient name]** includes:

1. **Diagnosis:**
2. **Clinical symptoms, including: [list patient symptoms]**
3. **Reason for prescribing LILETTA: [initiation of therapy, clinical worsening, combination therapy, failed previous therapy]**
4. **[additional information as needed]**

The documentation submitted for review with this letter of medical necessity includes: [list documents]

Example

- *Most current progress report that lists the diagnosis and physician request for* LILETTA
- *Journal articles*
- *Denial of coverage letter*
- *[additional examples as needed]*

If you require additional information, please contact **[contact information]**.

Thank you for your consideration. Your prompt approval for LILETTA would help this patient receive treatment that is necessary for her care.

Sincerely,
[Signature]
[date]
[Print name]
[Address]
[Phone number] [Fax number]

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FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

PRIOR AUTHORIZATION APPROVED

Dear Dr <Prescriber Name>,

Thank you for choosing **LILETTA AccessConnect℠**. The Program has been notified that the patient's insurance, <INSURANCE>, has approved the prior authorization request submitted for **LILETTA**.

Please see the attached Patient Benefit Summary Report for the above listed patient's LILETTA therapy as a reminder of benefits.

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.

Sincerely,

LILETTA AccessConnect℠

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Fax: 844.410.9571

Patient Benefit Summary

Patient Information

Patient name: <First Last>	Patient ID: <UBC-xx-xxxxx-xxxxx>
Patient date of birth: <xx/xx/xxxx>	Provider name: <Prescriber Name>

Summary of Benefits

	Pharmacy Benefit	Medical Benefit
Health insurance	<payer>	<payer>
Plan phone #	<xxx.xxx.xxxx>	<xxx.xxx.xxxx>
Policy #	<policy #>	<policy #>
Group #	<group #>	<group #>
Contracted specialty pharmacy(ies)	<Specialty pharmacy(ies)>	
Benefit Details		
Deductible	<$0.00>	<$0.00>
Deductible met	<$0.00>	<$0.00>
Copay/coinsurance	<$0.00>/<%>	<$0.00>/<%>
Out of pocket	<$0.00>	<$0.00>
Out of pocket met	<$0.00>	<$0.00>
Spend down	<$0.00>	<$0.00>
Additional information:		

THIS SUMMARY OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. Verbal verifications provided by insurers cannot take the place of written policy information, Explanation of Benefits (EOB) statement, or paid claims.

IMPORTANT NOTE

LILETTA AccessConnect℠ provides information about patient insurance benefits, including copay and coinsurance, for LILETTA. Information about other medications and treatments, including IUDs from other manufacturers, is not provided. The information provided by this service is for the benefit of the patient to understand possible insurance benefits. The information from LILETTA AccessConnect℠ is for informational purposes only and should not replace a review of benefits by the healthcare provider to determine coverage and reimbursement. Healthcare providers must follow the practices and procedure required by third-party payers when submitting claims for payment. The information available through LILETTA AccessConnect℠ is obtained directly from participating third-party payers providing primary health insurance coverage, not secondary health insurance coverage. Provision of information by participating third-party payers does not constitute an endorsement by the payer of LILETTA AccessConnect℠. Neither AbbVie nor United BioSource Corporation (UBC) guarantees or provides any warranties regarding the information provided, nor of the coverage, coding, or reimbursement of LILETTA or administration fees for insertions. 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. LILETTA AccessConnect℠ does not adjudicate or otherwise submit claims to third-party payers.

There is no obligation upon the healthcare provider or the patient that the patient be administered an AbbVie product after a benefits investigation is performed. The healthcare provider is responsible to determine whether a product is indicated for and consistent with the medical needs of each patient; eligibility for reimbursement by a particular payer is not a representation that the product is appropriate for that patient. Benefits investigation results for a patient will not result in entries or revisions to the medical records of the patient, nor will it result in entries to third-party payer claims-made or claims-paid records. Information about reimbursement eligibility submitted through LILETTA AccessConnect℠ is not a requirement for submission of claims to third-party payers. No patient information will be provided to AbbVie by UBC, the service provider engaged by AbbVie to operate the services offered through LILETTA AccessConnect℠.

IMPORTANT WARNING

This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy this document.

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FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

PRIOR AUTHORIZATION APPROVED

Dear Dr <Prescriber Name>,

Thank you for choosing **LILETTA AccessConnect℠**. The Program has been notified that the patient's insurance, <INSURANCE>, has approved the prior authorization request submitted for **LILETTA**.

It appears that your patient might be eligible for the LILETTA Patient Savings Program®* where your patient may receive assistance with out-of-pocket costs greater than $100, up to a maximum savings limit of $750. Please give your patient a LILETTA Patient Savings Program® brochure and tell her to visit www.LILETTAcard.com or call 855.706.4508 for assistance.

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.

Sincerely,

LILETTA AccessConnect℠

*Depending on insurance coverage, eligible patients pay $100, then save up to a maximum of $750 for the LILETTA® product. Offer applies to product only, and does not apply to costs associated with medical examination or product administration. Check with your pharmacist or healthcare provider for your copay discount. Patient out-of-pocket expense may vary. Offer not valid for patients enrolled in Medicare, Medicaid, or other federal or state healthcare programs. **Please see full LILETTA Patient Savings Program® Terms, Conditions, and Eligibility Criteria at LILETTA.com.**

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Patient Benefit Summary

Patient Information

Patient name: <First Last>	Patient ID: <UBC-xx-xxxxx-xxxxx>
Patient date of birth: <xx/xx/xxxx>	Provider name: <Prescriber Name>

Summary of Benefits

	Pharmacy Benefit	Medical Benefit
Health insurance	<payer>	<payer>
Plan phone #	<xxx.xxx.xxxx>	<xxx.xxx.xxxx>
Policy #	<policy #>	<policy #>
Group #	<group #>	<group #>
Contracted specialty pharmacy(ies)	<Specialty pharmacy(ies)>	
Benefit Details		
Deductible	<$0.00>	<$0.00>
Deductible met	<$0.00>	<$0.00>
Copay/coinsurance	<$0.00>/<%>	<$0.00>/<%>
Out of pocket	<$0.00>	<$0.00>
Out of pocket met	<$0.00>	<$0.00>
Spend down	<$0.00>	<$0.00>
Additional information:		

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There is no obligation upon the healthcare provider or the patient that the patient be administered an AbbVie product after a benefits investigation is performed. The healthcare provider is responsible to determine whether a product is indicated for and consistent with the medical needs of each patient; eligibility for reimbursement by a particular payer is not a representation that the product is appropriate for that patient. Benefits investigation results for a patient will not result in entries or revisions to the medical records of the patient, nor will it result in entries to third-party payer claims-made or claims-paid records. Information about reimbursement eligibility submitted through LILETTA AccessConnect℠ is not a requirement for submission of claims to third-party payers. No patient information will be provided to AbbVie by UBC, the service provider engaged by AbbVie to operate the services offered through LILETTA AccessConnect℠.

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US-LLT-220221 01/23

LILETTA ACCESSCONNECT℠
PO Box 66551 • St Louis, MO 63166-6551
Phone: 855-LILETTA (855.545.3882)
Fax: 844.410.9571

FAX:

To:	Dr <Prescriber Name>	**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	2
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:	<Pt. First Last>, <DOB>		
Hub/Case ID:	<UBC-14-xxxxx-xxxxx>		

PRIOR AUTHORIZATION APPROVED

Dear Dr <Prescriber Name>,

Thank you for choosing **LILETTA AccessConnect℠**. The Program has been notified that the patient's insurance, <INSURANCE>, has approved the prior authorization request submitted for **LILETTA**.

Please be aware that additional third-party assistance may be available to help with the costs of your patient's healthcare. Subject to availability of funds and individual program criteria, your patient may be eligible for additional assistance with coinsurance, premium, and/or deductible as well as other sources of assistance. **Based on information provided on the patient information form, it appears that your patient may be eligible for additional assistance from the following program(s):**

<Alternate Fund/Coverage
Phone Number Website>

Please encourage your patient to apply directly to this coverage option. We are available to assist you and your patient in any way we can.

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.

Sincerely,

LILETTA AccessConnect℠

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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Patient Benefit Summary

Patient Information

Patient name: <First Last>	Patient ID: <UBC-xx-xxxxx-xxxxx>
Patient date of birth: <xx/xx/xxxx>	Provider name: <Prescriber Name>

Summary of Benefits

	Pharmacy Benefit	Medical Benefit
Health insurance	<payer>	<payer>
Plan phone #	<xxx.xxx.xxxx>	<xxx.xxx.xxxx>
Policy #	<policy #>	<policy #>
Group #	<group #>	<group #>
Contracted specialty pharmacy(ies)	<Specialty pharmacy(ies)>	
Benefit Details		
Deductible	<$0.00>	<$0.00>
Deductible met	<$0.00>	<$0.00>
Copay/coinsurance	<$0.00>/<%>	<$0.00>/<%>
Out of pocket	<$0.00>	<$0.00>
Out of pocket met	<$0.00>	<$0.00>
Spend down	<$0.00>	<$0.00>
Additional information:		

THIS SUMMARY OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. Verbal verifications provided by insurers cannot take the place of written policy information, Explanation of Benefits (EOB) statement, or paid claims.

IMPORTANT NOTE

LILETTA AccessConnect℠ provides information about patient insurance benefits, including copay and coinsurance, for LILETTA. Information about other medications and treatments, including IUDs from other manufacturers, is not provided. The information provided by this service is for the benefit of the patient to understand possible insurance benefits. The information from LILETTA AccessConnect℠ is for informational purposes only and should not replace a review of benefits by the healthcare provider to determine coverage and reimbursement. Healthcare providers must follow the practices and procedure required by third-party payers when submitting claims for payment. The information available through LILETTA AccessConnect℠ is obtained directly from participating third-party payers providing primary health insurance coverage, not secondary health insurance coverage. Provision of information by participating third-party payers does not constitute an endorsement by the payer of LILETTA AccessConnect℠. Neither AbbVie nor United BioSource Corporation (UBC) guarantees or provides any warranties regarding the information provided, nor of the coverage, coding, or reimbursement of LILETTA or administration fees for insertions. 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. LILETTA AccessConnect℠ does not adjudicate or otherwise submit claims to third-party payers.

There is no obligation upon the healthcare provider or the patient that the patient be administered an AbbVie product after a benefits investigation is performed. The healthcare provider is responsible to determine whether a product is indicated for and consistent with the medical needs of each patient; eligibility for reimbursement by a particular payer is not a representation that the product is appropriate for that patient. Benefits investigation results for a patient will not result in entries or revisions to the medical records of the patient, nor will it result in entries to third-party payer claims-made or claims-paid records. Information about reimbursement eligibility submitted through LILETTA AccessConnect℠ is not a requirement for submission of claims to third-party payers. No patient information will be provided to AbbVie by UBC, the service provider engaged by AbbVie to operate the services offered through LILETTA AccessConnect℠.

IMPORTANT WARNING

This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and destroy this document.

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Medical Information Vendor Report—Confidential

Fax AE to: 908.248.0805

Securely Email Product Complaint to: AUS-PSReporting@allergan.com

Patient Information: ☐ **ADVERSE EVENT** ☐ **PRODUCT COMPLAINT**

Patient Name or Initials:			**Date of Birth:**
Sex: ☐ Male ☐ Female	**Street Address:**		
City:		**State:**	**ZIP:**

Patient Information:

Physician Name:		**Phone:**	
Street Address:		**City:**	**State:**	**ZIP:**

Product Name:

Product:	**LILETTA**		
Start Date:		**Stop Date** (if applicable):	
Lot # (relevant to event):		**Expiration Date:**	

If lot number is unknown or unavailable, check ONE box below to explain the reason.

☐ Primary reporter does not have the lot number information

☐ Primary reporter declined to provide lot number information

Event Information: ☐ **Patient Agrees to have MD contacted**

Date onset (symptoms, signs, and/or diagnosis):	**Contact #:**
Reporter Name:	☐ **Patient** ☐ **Family Member** ☐ **HCP** ☐ **Other**

Event Description:

(Please describe symptoms, signs, diagnosis, causality, treatment received (including any treatment medications), diagnostics, and lab values associated with this event.)

Medical Information Request (IR-MedCom@allergan.com) ☐ Specify below:

Please contact:	**Phone:**

Vendor/Program Name: United BioSource Corporation (UBC)			
Date Vendor informed of event:	<Date>	**Date Vendor notified AbbVie:**	<Date>
Personnel reporting event to AbbVie	<USER>		
Vendor Contact Number	844.410.9569		

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Liletta® (levonorgestrel-releasing intrauterine system) 52 mg | ACCESS CONNECT™

FAX COVER SHEET:

To:		**From:**	LILETTA AccessConnect℠
FAX:	<xxx-xxx-xxxx>	**Pages:**	1
Phone:	<xxx-xxx-xxxx>	**Date:**	
Re:			

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