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** _____

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