Liletta®
(levonorgestrel-releasing intrauterine system) 52 mg

MANUAL BENEFITS INVESTIGATION
PATIENT INFORMATION FORM
Please complete and fax this form to 1-844-410-9571
For assistance or additional information, call **855-LILETTA**
(**855.545.3882**) Monday–Friday, 8 am–5 pm CT

1. PATIENT INFORMATION

NAME (First, MI, Last)_____ DOB (MM/DD/YYYY) _____
ADDRESS _____ CITY _____
STATE_____ ZIP CODE_____ E-MAIL _____
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 TELEPHONE _____
POLICY ID #_____ GROUP#_____ POLICY HOLDER: _____
SECONDARY INSURANCE_____ INSURANCE TELEPHONE _____
POLICY ID #_____ GROUP #_____ POLICY HOLDER:_____
PHARMACY PLAN NAME_____ PBM PHONE NUMBER _____
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_____ PHONE_____ FAX _____
TAX ID #_____ BCBS #_____ MEDICAID #/PIN _____
STATE LICENSE #_____ SPECIALTY_____ MEDICARE PLAN_____

4. CLINICAL INFORMATION

DIAGNOSIS ☐ V25.11 ☐ OTHER _____

5. PHYSICIAN ATTESTATION

By signing this form, I certify that therapy with LILETTA is medically necessary for this patient. I will be supervising the patient's treatment accordingly and I have reviewed the current LILETTA prescribing information. I attest that I am acting on behalf of the patient and I have the necessary Health Insurance Portability and Accountability Act, HIPAA, authorization from the patient to release the 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 USA, Inc., 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_____

P.O. Box 66551 ◆ St. Louis, MO 63166-6551