

Specialty Pharmacy Request Form

Complete the form below and fax it back to your chosen specialty pharmacy.

SPECIALTY PHARMACY (Choose one)			
Specialty Pharmacy	Fax	Phone	Hours of Operation
<input type="checkbox"/> Biologics by McKesson	1-855-215-5315	1-888-275-8596	Mon-Fri 9:00 AM - 6:00 PM ET
<input type="checkbox"/> City Drugs	1-212-988-4501	1-855-988-4500	Mon-Fri 9:00 AM - 7:00 PM ET Sat 9:00 AM - 3:00 PM ET

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Cell Phone: _____

Date of Birth: _____

See Attached Demographic Sheet

PRESCRIBER INFORMATION

Prescriber Name: _____

State Lic #: _____

NPI #: _____ Specialty: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Ship To Address (Required): _____

City: _____ **State:** _____ **Zip:** _____

Prescriber's Phone: _____

Prescriber's Fax: _____

PREFERRED COMMUNICATION

Office Contact Name: _____

Direct Phone Number: _____

Direct Email Address: _____

Direct Fax: _____

INSURANCE INFORMATION (Please attach copies of front & back of cards)

Primary Insurance	Secondary Insurance	Rx Card (PRM)
Insurance: _____	Insurance: _____	(PRM): _____
City: _____ State: _____	City: _____ State: _____	PBM BIN: _____
Plan #: _____	Plan #: _____	City: _____ State: _____
Group #: _____	Group #: _____	Group #: _____
Phone #: _____	Phone #: _____	Phone #: _____
Subscriber Name (First/Last): _____	Subscriber Name (First/Last): _____	Subscriber Name (First/Last): _____
ID #: _____	ID #: _____	ID #: _____
Employer: _____	Employer: _____	Employer: _____

PRESCRIPTION INFORMATION

PAR T380A – QTY 1/Paragard (intrauterine copper contraceptive)

DIAGNOSTIC INFORMATION (ICD-10 Code)

Z30.430: Encounter for insertion of intrauterine contraceptive device

Other: Please Specify _____

If patient is a minor and is signing the authorization on the following page on her own behalf, please affirm that:

- This patient has the capacity to consent to treatment with Paragard under the law of the state in which I practice (and the consent of a parent or guardian is not required), or
- This patient's parent or guardian has consented to the patient's treatment with Paragard, as required by applicable state law.

I understand that my signature will be used as an approval allowing the Specialty Pharmacy to dispense Paragard. If I have a financial responsibility for obtaining Paragard, I understand that the selected specialty pharmacy will contact me prior to the dispense.

Patient Signature: _____ **Date:** _____

Prescriber Signature: _____ **Date:** _____

For ARNP, NP, and PA, collaborative physician agreement is with: _____ **Date:** _____

IMPORTANT: Prescriber gives the selected specialty pharmacy express permission to use his/her NPI number included herein for the purpose of identifying the referring prescriber to the authorized pharmacy benefits manager and/or payer. The selected specialty pharmacy accepts no liability regarding any decisions concerning claims, coverage or payment, which are made in the sole discretion of the health plan administrators and insurers. The selected specialty pharmacy makes no assurance that any prescribed drug will be covered or reimbursed at any specific level under any patient's insurance plan, or that any specific pharmacy will provide the prescribed drug.

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Patient Authorization for Specialty Pharmacy

In accordance with the Health Insurance Portability and Accountability Act of 1996 and related federal regulations and rules (“HIPAA”), this Authorization authorizes my healthcare provider, health plan, and my pharmacy to disclose my health and personal information to CooperSurgical, Inc. and its specialty pharmacy agents (and their affiliates, respective representatives, and agents) in furtherance of the below-stated authorized purposes.

Authorized Purposes

I understand that the selected specialty pharmacy will receive my health and personal information, which may include my name, address, patient insurance identification number, date of birth and other information necessary to obtain health insurance benefit verification for the following purposes: (1) the administration of CooperSurgical’s Paragard Program; (2) to conduct benefit verification determining insurance reimbursement and coverage of Paragard; (3) to contact me to discuss any relevant co-pay; (4) bill the insurance company; (5) bill the applicable co-pay; (6) ship the unit to my healthcare provider; (7) to contact me by telephone in furtherance of conducting benefits verifications investigations and/or specialty pharmacy dispense; and (8) if I choose to self-pay for Paragard, to invoice me and to otherwise contact me to collect payment for the Paragard unit.

By signing the following form, I understand:

1. Once my healthcare provider gives the selected specialty pharmacy information about me based on this Authorization, my medical and health information may be subject to redisclosure and is no longer protected by federal privacy regulations.

I further understand and agree that the selected specialty pharmacy may retain my medical and health information as disclosed under this Authorization after this Authorization expires.

I also understand that in the event of an audit, and for purposes of such an audit, some information may also be disclosed to CooperSurgical, Inc., the manufacturer of Paragard, or its affiliates after this Authorization has expired, so long as the audit is for a period of time when this Authorization was in effect.

2. I may refuse to sign this Authorization form and that, unless allowed by law, my refusal to sign will not affect my ability to obtain treatment from my healthcare provider; or to seek payment; or my eligibility for insurance benefits.
3. I may revoke my authorization at any time by providing a written notice of same to my healthcare provider, health plan and/or pharmacy that refers to (or with a copy of) this Authorization form, or to the selected specialty pharmacy. I understand that if I revoke this Authorization, it will not affect prior disclosures made to the selected specialty pharmacy and any use of such information by the selected specialty pharmacy in reliance of this Authorization. I understand that I have the right to receive a copy of this Authorization.
4. This Authorization shall expire one year after I have signed it, or upon revocation, whichever is earlier.

Signature of Patient or Legal Personal Representative: _____ **Date:** _____

Name of Patient or Legal Personal Representative: _____

(If Applicable) Description of Personal Representative’s Authority to Sign for Patient:

Please see Important Safety Information and Full Prescribing Information for Paragard at Paragard.com.

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