

LILETTA™ (levonorgestrel-releasing intrauterine system)

PRESCRIPTION & ENROLLMENT FORM

Four simple steps to submit your referral.

1 PATIENT INFORMATION

New patient Current

Patient's name _____
Date of birth _____ Female Last 4 digits of SSN _____
Street address _____ Apt # _____
City _____ State _____ ZIP _____
Parent/guardian (if applicable) _____
Home phone _____ Work phone _____ Cell phone _____
Evening phone _____ E-mail address _____
Patient's primary language: English Other If other, please specify _____

Please attach front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
Insured's name _____
Insured's employer _____ Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card: Yes No If yes, carrier _____
Policy # _____ Group # _____
Is patient eligible for Medicare? Yes No Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
Prescriber's name and title _____
If NP or PA, under direction of Dr. _____
Office contact and title _____
Clinic/hospital affiliation _____
Street address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____
Deliver product to: Office Clinic
Clinic location _____

Please fax completed form to your drug therapy team at 888.355.6682.

To reach your team, call toll-free 866.759.1557.

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3 CLINICAL INFORMATION

Primary ICD-10 code: _____
Other (List ICD-10) _____
Date of last menses _____ Date of last negative pregnancy test _____
Past medical history _____
Pertinent Obstetric History: _____
Requested Date of Delivery _____ Scheduled Insertion Date _____
 NKDA Known drug/non-drug allergies _____
Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity
<input type="checkbox"/> Liletta (levonorgestrel-releasing intrauterine system, single- handed insertion device)	<input type="checkbox"/> 52 mg	To be inserted intrauterinely by a healthcare provider for prevention of pregnancy up to but not exceeding 3 years.	Quantity: 1 No Refills

This form is for patient-specific orders billed through the pharmacy benefit. Please contact ANDA at 855.LILETTA (855.545.3882) to place a buy and bill order for office stock.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

I authorize HUB* to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

*HUB=LILETTA AccessConnectSM. LILETTA AccessConnectSM is a service mark of Odyssea Pharma SPRL, an Allergan affiliate.

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