LILETTA™ (levonorgestrel-releasing intrauterine system)

PRESCRIPTION & ENROLLMENT FORM

accredo®

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.

ORP-00004-091117 amc8399 CRP1706 _ A0191

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
❑ Liletta (levonorgestrel-releasing intrauterine system, single-handed insertion device)	❑ 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 AccessConnect℠. LILETTA AccessConnect℠ is a service mark of Odyssea Pharma SPRL, an Allergan affiliate.

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