

# 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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