CVS CAREMARK

Direct Service Request Form

Phone: 866-318-3492 Fax: 866-769-3882

IMPLANON® (etonogestrel implant) 68 mg

NEXPLANON® (etonogestrel implant)

Patient Benefit Verification and/or Prescription Order (For Patient Pharmacy Benefit)

Requested Services

Product: ❑ **NEXPLANON** ❑**IMPLANON**

Services Requested: ❑ Benefit Verification ❑ Prescription Order ❑ Buy and Bill Purchase

Patient Information

Last Name: _____ First Name: _____ MI: ___ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Alternative Phone: _____ Primary Language: _____

Patient Insurance Information

Copy and attach front and back of insurance card and prescription drug card

Prescription Drug Card: _____

Phone: _____ BIN: _____

PCN: _____ Policy #: _____ Group #: _____

Policy Holder Information (If different from patient)

Name: _____

Employer: _____ SS#: _____

Relation to Patient: _____

Medical Insurance: _____

Phone: _____

Policy #: _____ Group #: _____

Name: _____

Employer: _____ SS#: _____

Relation to Patient: _____

Patient has no insurance and/or does not want insurance billed. Requests Self Pay option: ❑ Single payment ❑ 3-month payment plan

Patient Authorization

(For benefit investigation request only)

I understand that in order for Caremark L.L.C. and Schering Corp. (hereafter "Merck"), a subsidiary of Merck & Co., Inc. to provide me with assistance, they will need to obtain, review, use and disclose my personal health information (PHI), including information relating to my medical condition and information on my request form, and any prescription. I authorize my physician, pharmacy(ies) and my health plan(s) to disclose my PHI to Caremark L.L.C. and their administrators as necessary to complete the insurance investigation process. I further authorize Caremark L.L.C. and their administrators to use my PHI to provide services through this program, and to disclose the information to my health plan(s), and their contractors for the purpose of coordination of benefits, reimbursement support, investigating insurance coverage and to coordinate the delivery, receipt and storage of my IMPLANON or NEXPLANON prescription medication for the sole purpose of administration by my prescribing provider. The prescribing provider listed below is my healthcare agent who administers IMPLANON or NEXPLANON at his/her medical facility.

I agree to allow Caremark L.L.C. to contact me via mail, telephone, or email in connection with carrying out these services. I understand that my name, address, and any other personal identifying information provided in my request form will be available to Caremark L.L.C. , and their affiliates. I understand that my PHI disclosed under this request may no longer be protected by privacy laws and may be re-disclosed by Caremark L.L.C. only for the purposes described herein. I also understand that non-identifiable information concerning individuals requesting assistance with insurance coverage may be summarized for statistical or other purposes and provided to Merck by Caremark L.L.C., but my identity will not be determinable from such summary information.

I understand that if I don't provide an Authorization, I will not be able to obtain service program assistance provided by Caremark, L.L.C. on behalf of Merck. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to my prescribing physician, pharmacy, health plans and Caremark L.L.C., and the cancellation will not apply to any information already used or disclosed pursuant to this Authorization.

If I don't cancel this Authorization, the Authorization will expire 15 months from the date signed below. Merck has retained Caremark L.L.C. to provide services to customers, including reimbursement services. Information and questions related to the information provided in regard to this request should be referred directly to Caremark L.L.C. Merck personnel are not aware of patient specific reimbursement information and are not permitted to discuss such information with customers. I have read this document or have had it explained to me. I understand that I may request a copy of this Authorization once it has been signed.

Patient signature: _____ Date: ____/____/____

Signature of legal representative (if applicable) _____ Date: ____/____/____

Prescriber Information

(IMPLANON OR NEXPLANON -trained clinician)

Prescriber Name (First, Last): _____ Title: ❑ MD ❑ DO ❑ NP ❑ PA

Name of Practice: _____

Office Contact: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ State Medical License #: _____ Expiration Date: _____

NPI #: _____ Contact Preference: ❑ Phone ❑ Fax ❑ Email

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

Prescription Information

(Patient-Specific Order for specialty pharmacy dispensing)

Dispense 1 ❑ ***Rx NEXPLANON (etonogestrel implant) 68 mg*** 1 ❑ ***Rx IMPLANON (etonogestrel implant) 68 mg***

SIG: **To be inserted one time by prescriber subdermally**

❑ V25.5 ❑ V25.43 ❑ V45.52 ❑ Other: _____

_____ Product Substitution Permitted (signature) Date

_____ Dispense as written (signature) Date

Allergies: _____ Date of Last Menses: _____

I certify that I have completed an IMPLANON training program if ordering IMPLANON, and that I have completed NEXPLANON training if ordering NEXPLANON. If not certified, please contact your sales representative.

Prescriber's Signature: _____ **Date:** _____

Notification: By submitting this prescription request form, prescriber is aware that CVS Caremark will ship upon verification of benefits and collection of applicable copay. If there is a zero-dollar copay, patient will not be contacted. CVS Caremark will ship to prescriber's office, and will not contact prescriber before shipping.

CVS CAREMARK

Buy and Bill Order Form

Phone: 866-318-3492 Fax: 866-769-3882

IMPLANON® (etonogestrel implant) 68 mg

NEXPLANON® (etonogestrel implant)

Purchase of IMPLANON and/or NEXPLANON (Buy and Bill)

Prescriber Information

(IMPLANON OR NEXPLANON-trained clinician)

Prescriber Name (First, Last): _____ Title: ❑ MD ❑ DO ❑ NP ❑ PA

Name of Practice: _____

Office Contact: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ State Medical License #: _____ Expiration Date: _____

NPI #: _____ Contact Preference: ❑ Phone ❑ Fax ❑ Email

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

Shipping Information

Ship to: ❑ Prescriber's Address Above ❑ Address Below Requested Delivery Date: _____

Prescriber, Institution or Practice Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Contact Name: _____

CVS Caremark will invoice Purchaser at the time of each shipment. Payment to CVS Caremark for the products is due and payable within ninety (90) days after the date of CVS Caremark's related invoice ("Payment Due Date"). Purchaser must sign a letter of agreement prior to first shipment.

Buy & Bill

(Prescriber purchases, billed to the prescriber)

Bill to Address - Account Holder (If different than shipping information)

Physician, Institution or Practice Name: _____ HIN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Contact Name: _____

Quantity Requested: _____ PRODUCT: IMPLANON NDC: 00052-0272-01 Purchase Order # (if required by practice or institution): _____

Quantity Requested: _____ PRODUCT: NEXPLANON NDC: 00052-0274-01

Credit Card: Name on Card: _____ Account #: _____ Exp. Date: _____

Form of Business: ❑ Hospital ❑ Private Practice ❑ PHS (340B) ❑ Sub PHS (340B Prime Vendor) ❑ FSS (DoD, VA, IHS)
❑ Planned Parenthood ❑ Other (please specify):

Tax Identification Number: FEIN: _____ SSN: _____
Submit copy of tax exempt certificate if eligible *(If FEIN not available)*

Provider will be invoiced for all products [IMPLANON or NEXPLANON] purchased from Caremark, L.L.C. at the rates quoted at the point-of-sale. Provider is financially responsible for, and agrees to pay, Caremark, L.L.C. all invoiced charges for products ordered by Provider. Each invoice will be due and payable by Provider within the payment terms offered by Caremark, L.L.C. on the date-of-order.

Signature: _____ Print Name and Title: _____ Date: _____

If different from signature, provide the name of the IMPLANON and/or NEXPLANON trained clinician responsible for this order: _____

NOTE: To order NEXPLANON, NEXPLANON-specific training is required. To order IMPLANON, IMPLANON-specific training is required.

The information provided in response to your request for insurance coverage assistance will be based on statements of individuals not affiliated with Caremark, L.L.C or Schering Corporation (Merck), a subsidiary of Merck & Co., Inc. Neither Merck nor Caremark, L.L.C. make any warranties, expressed or implied, about the accuracy of this information. Insurance coverage status can change over time based on a variety of factors including, processing of additional claims that impact deductibles and/or coverage limits, changes in benefit design and a patient's change in insurance carrier. The coverage information to be provided is intended for your reference only and does not guarantee current or future coverage for IMPLANON or NEXPLANON.

Individual patient coverage reports will be made available to the extent that information is made available by the insurance plan. The goal is to respond to your request in one to two business days. This timing cannot be guaranteed based on the willingness of insurance companies to release insurance coverage information.

Fax to: 866-769-3882

CVS CAREMARK

Important Instructions

When completing/submitting your Direct Service Request Form

CVS Caremark can verify patient benefits on behalf of the prescriber. To expedite this process, please take a moment to read these instructions and complete each section of the form. You may also order at www.cvs-implanondirect.com.


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Requested Services

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Services Requested: ☐ Benefit Verification ☐ Prescription Order ☐ Buy and Bill Purchase

1 Patient Information

Patient Insurance Information

Patient Authorization

2 Prescriber Information (IMPLANON OR NEXPLANON trained clinician)

Prescription Information


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Patient Insurance Information

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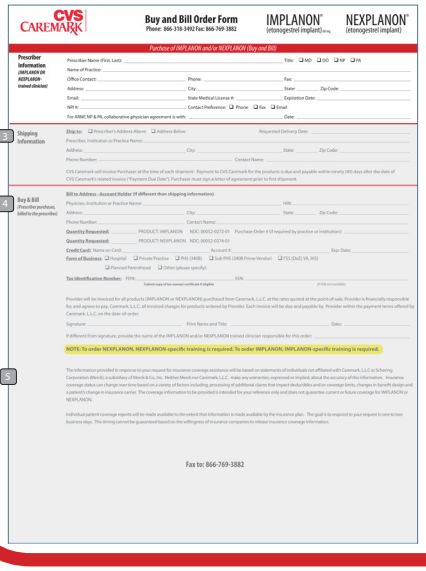
2 Prescriber Information (IMPLANON OR NEXPLANON trained clinician)

Prescription Information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Purchase of IMPLANON and/or NEXPLANON (Buy and Bill)

Prescriber Information (IMPLANON OR NEXPLANON trained clinician)

3 Shipping Information

4 Buy & Bill Prescriber purchases, billed to the prescriber

5

Fax to: 866-769-3882

1 Patient Benefit Verification

NOTE: Please notify your patients that CVS Caremark will attempt to reach them by phone to verify their acceptance of the product if there is a financial responsibility due.

PATIENT INFORMATION: Please provide complete contact information for the patient.

PATIENT AUTHORIZATION: Please have patient read, sign and date.

PRESCRIBER: The prescriber listed on the form must be trained in the insertion and removal of IMPLANON if prescribing IMPLANON, or NEXPLANON, if prescribing NEXPLANON.

2 Prescription Information

NOTE: To order IMPLANON and/or NEXPLANON by prescription for a participating patient, please complete the prescription section, in addition to patient information, patient insurance information, and prescriber information sections.

PRESCRIBER SIGNATURE: The individual signing this form must be the trained clinician who will be inserting IMPLANON and/or NEXPLANON.

NOTE: If your patient will be paying by cash, you may use this form as a prescription. Please check the box of either single payment or 3 month payment plan under the "Insurance Information" portion of this form. Product will ship without patient contact if the patient has zero financial responsibility.

3 Shipping Information

NOTE: It is important that all shipping information be completed prior to submitting this form. If you have a requested delivery date, please indicate in the space provided.

4 Buy and Bill Purchase

NOTE: To purchase IMPLANON and/or NEXPLANON for Buy and Bill, complete this section. This will allow IMPLANON Direct to ensure that IMPLANON and/or NEXPLANON is received on time. Purchaser must sign a letter of agreement with CVS Caremark prior to first shipment.

SIGNATURE AUTHORIZATION: Buy and Bill purchases must be authorized by an individual with purchasing authority.

If this person is not trained on the product purchased, please identify the trained clinician responsible for the order.

5 Faxing the Form

Please fax the completed form, along with both sides of the patient's insurance card and prescription drug card, to 866-769-3882.

Before submitting, remember to....

- ☐ Indicate product requested
- ☐ Indicate services requested
- ☐ Fill in the patient's information, including Social Security Number; have patient sign
- ☐ Make sure the prescriber listed on the form is trained in inserting IMPLANON and/or NEXPLANON
- ☐ Accurately and thoroughly complete the Insurance Information section, including all corresponding codes
- ☐ Fax the completed form along with both sides of the patient's insurance card
- ☐ **To contact IMPLANON Direct with any questions or concerns, please call 866-318-3492**

IMPLANON® (etonogestrel implant) 68 mg

NEXPLANON® (etonogestrel implant)

www.IMPLANON-USA.com

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