

## Specialty Pharmacy Request Form

Complete the form, then fax pages 1 and 2 to your chosen specialty pharmacy. Give page 3 to the patient.

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 – A BioMatrix Specialty Pharmacy	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	PRESCRIBER INFORMATION
Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____ Date of Birth: _____ <input type="checkbox"/> See Attached Demographic Sheet	Prescriber Name: <u>Jennifer Cho M.D</u> State Lic #: _____ NPI #: _____ Specialty: <u>Gynecology</u> Facility Name: <u>Bergen County Gynecology</u> Address: <u>106 Grand Ave Suite 300</u> City: <u>Englewood</u> State: <u>NJ</u> Zip: <u>07631</u> <b>Ship To Address (Required):</b> <u>106 Grand Ave Suite 300</u> <b>City:</b> <u>Englewood</u> <b>State:</b> <u>NJ</u> <b>Zip:</b> <u>07631</u> Prescriber's Phone: <u>201-608-0670</u> Prescriber's Fax: <u>201-781-7821</u> <b>PREFERRED COMMUNICATION</b> Office Contact Name: <u>Crystal Leslie</u> Direct Phone Number: <u>201-608-0670</u> Direct Email Address: <u>officemanager@bcgynecology.com</u> Direct Fax: <u>201-781-7821</u>

INSURANCE INFORMATION (Please attach copies of front & back of cards)			<input type="checkbox"/> N/A (Patient Self-Pay)
Primary Insurance: _____ City: _____ State: _____ Plan #: _____ Group #: _____ Phone #: _____ Subscriber Name (First/Last): _____ ID #: _____ Employer: _____	Secondary Insurance: _____ City: _____ State: _____ Plan #: _____ Group #: _____ Phone #: _____ Subscriber Name (First/Last): _____ ID #: _____ Employer: _____	Rx Card (PRM): _____ PBM BIN: _____ City: _____ State: _____ Group #: _____ Phone #: _____ Subscriber Name (First/Last): _____ ID #: _____ Employer: _____	

PRESCRIPTION INFORMATION	DIAGNOSTIC INFORMATION (ICD-10 Code)
<input checked="" type="checkbox"/> <b>PAR T380A – QTY 1</b> /Paragard (intrauterine copper contraceptive) to be inserted one time by prescriber.	<input checked="" type="checkbox"/> <b>Z30.430:</b> Encounter for insertion of intrauterine contraceptive device <input type="checkbox"/> <b>Other:</b> 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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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:**

\_\_\_\_\_

Dear Patient,

Your healthcare provider has ordered Paragard through the following specialty pharmacy. This specialty pharmacy may contact you regarding Paragard, or you may contact them directly if you have any questions.

**Specialty Pharmacy**

**Phone Number**

<input type="checkbox"/> Biologics by McKesson	1-888-275-8596
<input type="checkbox"/> City Drugs – A BioMatrix Specialty Pharmacy	1-855-988-4500

To learn more visit [Paragard.com](https://Paragard.com)