

Specialty Pharmacy Request Form

Complete the form and fax to chosen Specialty Pharmacy. Please give page 2 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"/> CenterWell Pharmacy (formerly Humana Pharmacy)	1-877-405-7940	1-800-486-2668	Mon-Fri 8:00 AM - 11:00 PM ET Sat 8:00 AM - 6:30 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: _____ State Lic #: _____ NPI #: _____ Specialty: _____ Facility Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Ship To Address (Required): _____ City: _____ State: _____ Zip: _____ Prescriber's Phone: _____ Prescriber's Fax: _____ PREFERRED COMMUNICATION Office Contact Name: _____ Direct Phone Number: _____ Direct Email Address: _____ Direct Fax: _____

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 type="checkbox"/> PAR T380A – QTY 1 /Paragard (intrauterine copper contraceptive) to be inserted one time by prescriber.	<input type="checkbox"/> Z30.430: Encounter for insertion of intrauterine contraceptive device <input type="checkbox"/> Other: 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:** ____/____/____

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"/> CenterWell Pharmacy (formerly Humana Pharmacy)	1-800-486-2668

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