Customer Support Center

Nexplanon®
(etonogestrel implant) 68mg
Radiopaque

Enrollment Form

Phone: 844-NEX-4321 (844-639-4321) • Fax: 844-232-2618

TO GET STARTED, COMPLETE THE ENROLLMENT FORM AND FAX IT TO 844-232-2618.

PLEASE CHECK ALL BOXES THAT APPLY AND COMPLETE THE APPROPRIATE SECTION(S) OF THE FORM

☐ Patient Benefit Investigation ☐ Prescription Order

SPECIALTY PHARMACY ORDER FOR ASSIGNMENT OF BENEFITS ONLY:

Please select **one** fulfillment option to indicate your preference. Note that some insurers may require use of a particular specialty pharmacy.

☐ Accredo Pharmacy ☐ AllianceRx Walgreens Prime ☐ Cigna Specialty Pharmacy Services

☐ CVS Health Pharmacy ☐ Humana Specialty Pharmacy ☐ Magellan Rx Pharmacy

PATIENT INFORMATION SECTION

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Primary Language: _____

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

Phone: _____ ☐ Home ☐ Cell Email: _____

Special Instructions: _____

Current Medications: _____

INSURANCE INFORMATION

PLEASE COMPLETE ALL THAT APPLY AND **INCLUDE A FRONT AND BACK COPY OF INSURANCE CARD** FOR EACH TYPE OF INSURANCE

☐ **Patient has no insurance and/or does not want insurance billed. Requests for Self Pay option available at preferred Specialty Pharmacy.**

Prescription Drug Card

Plan Name: _____

Payer Phone: _____ BIN: _____

PCN: _____ Policy #: _____ Group #: _____

Policy Holder Information (If different from patient)

Name: _____

Date of Birth: _____

Employer: _____

Relationship to Patient: _____

Medical Insurance

Plan Name: _____

Payer Phone: _____

Policy #: _____ Group #: _____

Policy Holder Information (If different from patient)

Name: _____

Date of Birth: _____

Employer: _____

Relationship to Patient: _____

PATIENT AUTHORIZATION (REQUIRED if "Prescription Order" has been requested above)

I understand that in order for Merck Sharp & Dohme B.V., a subsidiary of Merck & Co., Inc., and Lash (the company that will conduct reimbursement services on behalf of Merck) to provide me with assistance, Lash and its administrators (collectively, "Lash") will need to obtain, review, use, and disclose my personal health information related to my treatment with NEXPLANON, information on my request form,

Patient name: _____

PATIENT INFORMATION SECTION

PATIENT AUTHORIZATION (*continued*)

and any prescription for NEXPLANON® (etonogestrel implant) (my "PHI"). I authorize my physician, pharmacy(ies), and my health plan(s) to disclose my PHI to Lash as necessary to complete the insurance investigation process. I further authorize Lash and the Specialty Pharmacies (Accredo Pharmacy, AllianceRx Walgreens Prime, Cigna Specialty Pharmacy Services, CVS Health Pharmacy, Humana Specialty Pharmacy, or Magellan Rx Pharmacy) and their respective affiliates to exchange my PHI to provide support 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 coordination of the delivery, receipt and storage of my prescription medication for NEXPLANON for the sole purpose of administration to me by my prescribing provider named above.

I authorize the Specialty Pharmacy to use my PHI to contact me via mail, telephone, text, or email in connection with information related to this Enrollment Form. In order for the Specialty Pharmacy to ship my prescription medication for NEXPLANON directly to my prescribing provider, I authorize the Specialty Pharmacy to communicate with my prescribing provider about my PHI in order to coordinate the delivery, receipt, and storage of my prescription medication for NEXPLANON for the sole purpose of administration of my prescribing provider at my next scheduled appointment. I understand that my PHI disclosed pursuant to this Authorization may no longer be protected by certain federal privacy laws and may be re-disclosed by the recipient, but that Lash has agreed to use my PHI only for the purposes described herein.

I understand that if I do not sign this Authorization, that will not affect my receipt of treatment (including with NEXPLANON) or of health insurance benefits, but that I will not be able to obtain certain assistance provided by Lash on behalf of Merck. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to Lash, PO Box 741, Monroeville, PA, 15146-0741. I understand that canceling my Authorization will not affect uses and disclosures of PHI already made in reliance on the Authorization before my cancellation is received by Lash.

If I do not cancel this Authorization, the Authorization will expire 12 months from the date signed below. Merck has retained Lash and the Specialty Pharmacies to provide support to customers, including reimbursement support. Information and questions related to the information provided in regard to this request should be referred directly to Lash. 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:** _____

Print Name: _____ **Date:** _____

Relationship to patient if signing on their behalf: _____ **Date:** _____

If you have questions about completing this form or need additional information, please call 844-NEX-4321 (844-639-4321). Thank you.

Patient name: _____

PRESCRIBER INFORMATION SECTION

PRESCRIPTION INFORMATION (REQUIRED if "Prescription Order" has been requested)

Dispense: 1 ☐ **Rx NEXPLANON® (etonogestrel implant) 68 mg** Days supplied: 3 years Refills: 0 Allergies: _____

SIG: To be inserted one time by prescriber subdermally Date of Last Menses: _____

Please indicate the diagnosis code(s): ☐ **Z30.017** ☐ **Z30.46** ☐ **Other:** _____ Anticipated Insertion Date: _____

_____ _____

Product Substitution Permitted (Signature) Date Dispense as Written (Signature) Date

I certify that I have completed training for NEXPLANON. If not certified, please contact your sales representative.

PRESCRIBER INFORMATION (prescriber or collaborative physician must be trained on NEXPLANON)

Name: _____

Practice Name: _____

Office Contact: _____ Phone: _____ Fax: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Tax ID #: _____ State Medical License #: _____

NPI #: _____ Contact Preference: ☐ Phone ☐ Fax

For ARNP, NP & PA, and other, collaborative physician agreement is with: _____ NPI #: _____ Date: _____

PRESCRIBER AUTHORIZATION

MUST CONTAIN ORIGINAL SIGNATURE

- This request has been prepared exclusively by the physician or physician office identified in this request ("my Practice").
- My Practice has obtained written authorization from the patient identified in this request to disclose the patient's personal health information (PHI), including information relating to the patient's medical condition and prescription medications and the information disclosed in this Enrollment Form, as well as the information included in this request, to the Customer Support Center for NEXPLANON ("CSCN"), sponsored by Merck Sharp & Dohme Corp. ("Merck"), a subsidiary of Merck & Co., Inc., the administrators of the Program, including their contractors or other affiliates, and for the CSCN to use and disclose the information for the purposes of benefits investigation and reimbursement support.
- My Practice has provided the patient identified in this request with the notices necessary to comply with all federal and state laws and regulations relating to medical and/or health privacy, including, but not limited to, the HIPAA Privacy Rule, codified at 45 C.F.R. Parts 160 and 164, as amended from time to time.
- If my patient is a minor, I certify that either 1) this patient's parent or guardian has consented to the patient's treatment with NEXPLANON (as allowable under the law of the state in which I practice), or 2) I, or a physician in my Practice, have determined that this patient has the capacity to consent to treatment with NEXPLANON under the law of the state in which I practice (and that consent of a parent or guardian is not required).
- NOTICE: In the event that my patient's insurer provides coverage via an assignment of benefits, I understand that this Enrollment Form may also serve as a prescription that can, at my request, be forwarded to the relevant specialty pharmacy. However, I understand that prescribing and dispensing laws and regulations vary by state and that this form may NOT be consistent with the requirements (e.g., content or format) for a valid prescription in my state, in which case I am responsible for submitting a prescription to the relevant specialty pharmacy (or for including such form with this Enrollment Form) in a manner and on a form consistent with the requirements in my state. By submitting this Enrollment Form, I am aware that for assignment of benefit claims, the specialty pharmacy may ship product upon verification of benefits and collection of applicable co-pay. I understand that if there is no co-pay, the patient may not be contacted.
- I understand that information concerning program participants may be summarized for statistical or other purposes and provided to Merck and/or the CSCN.
- I understand that the Program reserves the right to conduct periodic audits of my Practice's records to verify the information provided herein, excluding patient-identifiable data (unless the auditor enters into an appropriate agreement with the Practice to protect an individual's medical privacy).
- I verify that the information provided is complete and accurate to the best of my knowledge.
- I acknowledge the following: Merck has retained Lash, a subsidiary of AmerisourceBergen, a supplier of reimbursement support, to support the CSCN. Information and questions related to the information provided in response to the submission of this form should be referred directly to Lash. Merck personnel are not aware of patient coverage information and are not permitted to discuss such information with customers. Communications in response to this form will be prepared for me by Lash, providing reimbursement assistance services for Merck products pursuant to an agreement with Merck, in response to my request for insurance coverage information regarding my patient. The information provided will be based on statements of individuals not affiliated with Lash, the CSCN, or Merck. Neither Lash, the CSCN, nor Merck 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. Any coverage information provided to me in response to this request is intended for my and my patient's reference only and does not guarantee current or future coverage for any Merck product. Individual patient coverage information is provided to the extent that information is made available by the insurance plan.

Prescriber original signature: _____ **Date:** _____

Prescriber (please print): _____

To report an adverse event for a specific Merck product, including death due to any cause, please contact the Merck National Service Center at 800-444-2080.

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MERCK