

Patient Demographic Information

1
Last Name: _____ First Name: _____ MI: _____
Address: _____ City: _____ State: _____ Zip Code: _____
County _____ Phone: _____ Alternate Phone: _____
DOB: _____ Gender: _____ Female

Patient Insurance Information (Please copy and attach the front and back of medical and prescription drug card insurance - Send with request)

2
Prescription Insurance: _____ Medical Insurance: _____
Phone: _____ Phone: _____
Subscriber #: _____ Group#: _____ Subscriber #: _____ Group#: _____
Policy Holder Information (If different from patient) **Policy Holder Information (If different from patient)**
Name: _____ Name: _____
Employer _____ Employer _____
Relation to Patient: _____ Relation to Patient: _____

Prescriber Information

Prescriber Name (First, Last): _____ Title (please check one) MD DO NP PA
Office Contact: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Ship to address if different from above: _____
Group or Hospital: _____ Physician Medicaid #: _____ License#: _____ NPI#: _____
 Prescriber has been trained in the placement of Mirena Prescriber has not been trained. Send a Mirena training kit.

Prescription Information (Patient-Specific Order for specialty pharmacy dispensing; CVS Caremark will ship upon verification of benefits and collection of applicable copay; CVS Caremark will ship to prescriber's office; Prescriber MUST call CVS Caremark at 866-638-8312 to cancel shipment)

Rx Mirena (levonorgestrel-releasing intrauterine system)
ICD-9: V25.1 626.2 627.0 Other (List ICD-9) _____ Date of last menses: _____ List Allergies: _____
 Dispense Mirena SIG: _____ For one time Intrauterine placement _____ Quantity: 1
Requested Date of Mirena Delivery: _____ Scheduled Placement Date: _____

Product Substitution Permitted	(Signature)	Date	Dispense As Written	(Signature)	Date
Supervising Physician Name	(Print)	Supervising Physician	(Signature)	Date	

Parental Consent

3
I, _____ patient/guardian (circle one), give CVS Caremark Specialty Pharmacy permission to bill my insurance company. CVS Caremark does not need to contact me when there is no copayment (\$0 copay). I understand this medication is being ordered by my doctor and will be delivered to and administered in my doctor's office.
Parent/Guardian Signature _____ Date _____

Credit Card Information

I give my consent for CVS Caremark to use my credit card/bank card information to bill for a copay up to \$50 as necessary without contacting me.
 American Express MasterCard Visa Card Number _____ Expiration Date _____ MM/YY
Cardholder Name (printed) _____
Cardholder Signature _____ Date _____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Mirena 012010 150.09.0039.09