CVS CAREMARK | Specialty Pharmacy

Mirena® Specialty Pharmacy Prescription Request Form

Phone: 866-638-8312 Fax: 866-216-1681

Mirena® (levonorgestrel-releasing intrauterine system) 52 mg per day

Patient Demographic Information

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)

Prescription Insurance: _____

Phone: _____

Subscriber #: _____ Group#: _____

Policy Holder Information (If different from patient)

Name: _____

Employer _____

Relation to Patient: _____

Medical Insurance: _____

Phone: _____

Subscriber #: _____ Group#: _____

Policy Holder Information (If different from patient)

Name: _____

Employer _____

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

Patient Consent

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 _____

Charge 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 _____