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.