PRESCRIBER INFORMATION SECTION

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

Patient Last Name: _____ Patient First Name: _____ Patient Date of Birth: _____

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: _____

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 Women's Health Account Specialist.

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

Last Name: _____ First Name: _____

NPI # _____ Contact Preference: ☐ Phone ☐ Fax ☐ Email

Office Email Address: _____

Practice/Facility Name: _____

Practice/Facility Address: _____ City: _____

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

Primary Office Contact: _____ Phone: _____ Ext. (if applicable): _____ Fax: _____

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

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 Organon, 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).
- I certify that I am authorized, pursuant to the laws of my state of licensure, to prescribe NEXPLANON.
- 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 Organon 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 consent to receive communications related to the CSCN by telephone, email, and/or fax.
- I verify that the information provided is complete and accurate to the best of my knowledge.
- I acknowledge the following: Organon has retained PharmaCord, LLC, 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 PharmaCord, LLC. Organon 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 PharmaCord, LLC, providing reimbursement assistance support for Organon products pursuant to an agreement with Organon, 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 PharmaCord, LLC, the CSCN, or Organon. Neither PharmaCord, LLC, the CSCN, nor Organon 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 Organon 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 Organon product, including death due to any cause, please contact the Organon Service Center at 844-674-3200.

CUSTOMER SUPPORT CENTER
PHONE: 844-NEX-4321 (844-639-4321) • FAX: 844-232-2618

ORGANON

PATIENT INFORMATION SECTION

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

I understand that in order for Organon LLC, a subsidiary of Organon & Co. ("Organon") and PharmaCord, LLC (the company that will conduct reimbursement support on behalf of Organon) to provide me with assistance, PharmaCord, LLC and its administrators (collectively, "PharmaCord, LLC") will need to obtain, review, use, and disclose my personal health information related to my treatment with NEXPLANON® (etonogestrel implant), information on my request form, and any prescription for NEXPLANON (my "PHI"). I authorize my physician, pharmacy(ies), and my health plan(s) to disclose my PHI to PharmaCord, LLC as necessary to complete the insurance investigation process. I further authorize PharmaCord, LLC and the Specialty Pharmacies (Accredo Health Group Inc., AllianceRx Walgreens Pharmacy, ASPN Pharmacies, LLC, CVS Specialty Pharmacy, CenterWell 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 and PharmaCord, LLC to use my PHI to contact me via mail, telephone, text, or email in connection with information related to this Enrollment Form. If contacted by the Specialty Pharmacy and/or PharmaCord, LLC via text, I understand that standard data rates apply. 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. If there is a $0 co-pay, my signature below serves as my consent for the Specialty Pharmacy to ship my prescription medication to my prescribing provider. 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 PharmaCord, LLC 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 PharmaCord, LLC on behalf of Organon. I understand that I may cancel this Authorization at any time by mailing a written request for such cancellation to CSCN, PO Box 1566, Jeffersonville, IN 47131. 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 PharmaCord, LLC.

If I do not cancel this Authorization, the Authorization will expire 15 months from the date of signature (or the maximum period allowed by applicable state law, if less than 15 months). Organon has retained PharmaCord, LLC 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 PharmaCord, LLC. Organon 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:** _____

Patient Name: _____

Patient Date of Birth: _____

Relationship to patient if signing on their behalf: _____

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

Customer Support Center

Nexplanon® (etonogestrel implant) 68mg Radiopaque

Enrollment Form

Version 2.0

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 THIS FORM

☐ Patient Benefit Investigation ☐ Prescription Order

SPECIALTY PHARMACY PREFERENCE (ONLY REQUIRED IF "PRESCRIPTION ORDER" IS REQUESTED ABOVE)

Please select **one** fulfillment option to indicate your preference.

☐ Accredo Health Group Inc. ☐ AllianceRx Walgreens Pharmacy ☐ ASPN Pharmacies, LLC

☐ CVS Specialty Pharmacy ☐ CenterWell Specialty Pharmacy ☐ Magellan Rx Pharmacy

Note: If the patient's insurer requires use of a particular specialty pharmacy, or if it is determined that the specialty pharmacy selected is not within the insurer's network, the CSCN will automatically triage the script to the required specialty pharmacy, or to an in-network specialty pharmacy.

If no selection is made, or if multiple specialty pharmacies are selected, the CSCN will triage to an in-network specialty pharmacy, if known. If unknown, the CSCN will contact your office to obtain the preferred specialty 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: _____