Customer Support Center

Nexplanon®
(etonogestrel implant) 68mg
Radiopaque

DIRECT SERVICE REQUEST FORM

PHONE: 844-NEX-4321 (844-639-4321) **FAX: 844-232-2618**

Services Requested: ☐ Benefit Investigation for NEXPLANON ☐ Benefit Investigation for IMPLANON® (etonogestrel implant) ☐ Prescription Order

Fulfillment Options: Specialty Pharmacy Order for Assignment of Benefits Only: ☐ Accredo Pharmacy ☐ CVS Health Pharmacy
(Please use a check mark to indicate your preference. Note that some insurers may require use of a particular specialty pharmacy.)

Prescriber Information
(clinician trained on NEXPLANON)

Prescriber Name (First, Last): _____ Title: ☐ MD ☐ DO ☐ ANRP ☐ NP ☐ PA ☐ Other: _____
Name of Practice: _____
Office Contact: _____ Phone: _____ Fax: _____
Address: _____ City: _____
State: ____ Zip Code: _____ Tax ID #: _____ State Medical License #: _____ Expiration Date: _____
NPI #: _____ Contact Preference: ☐ Phone ☐ Fax
For ARNP, NP & PA, and other, collaborative physician agreement is with: _____ Date: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ SS#: _____ Primary Language: _____
Address: _____ City: _____
State: ____ Zip Code: _____ Phone: _____ Alternative Phone: _____
Special Instructions: _____
Current Medications: _____

Patient Insurance Information
Copy and attach front and back of insurance card and prescription drug card

Prescription Drug Card: _____
Phone: _____ BIN: _____
PCN: _____ Policy #: _____ Group #: _____
Policy Holder Information (If different from patient)
Name: _____
Employer: _____ SS#: _____
Relationship to Patient: _____

Medical Insurance: _____
Phone: _____
Policy #: _____ Group #: _____
Policy Holder Information (If different from patient)
Name: _____
Employer: _____ SS#: _____
Relationship to Patient: _____

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

If your patient is a minor and is signing the authorization on the following page on her behalf, please affirm that

☐ **This patient has the capacity to consent to treatment with NEXPLANON under the law of the state in which I practice (and the consent of a parent or guardian is not required)**

OR

☐ **This patient's parent or guardian has consented to the patient's treatment with NEXPLANON**
(Does not apply to the following: Alaska, Arkansas, California, Colorado, District of Columbia, Georgia, Hawaii, Idaho, Iowa, Kentucky, Maryland, Minnesota, North Carolina, New Mexico, Oregon, Tennessee, or Virginia)

NOTICE: In the event that your patient's insurer provides coverage via an assignment of benefits, this Service Request Form may also serve as a prescription that can, at your request, be forwarded to the relevant specialty pharmacy. However, prescribing and dispensing laws and regulations vary by state and this form may NOT be consistent with the requirements (eg, content or format) for a valid prescription in your state, in which case you should submit a prescription to the relevant specialty pharmacy (or include such form with this Service Request Form) in a manner and on a form consistent with the requirements in your state. By submitting this Service Request Form, prescriber is aware that for assignment of benefit claims, the specialty pharmacy may ship product upon verification of benefits and collection of applicable co-pay. If there is no co-pay, patient may not be contacted.

Prescription Information
(Patient-Specific Order for specialty pharmacy dispensing)

Dispense: 1 ☐ **Rx NEXPLANON (etonogestrel implant) 68 mg** Days supplied: 3 years Refills: 0 Allergies: _____
SIG: To be inserted one time by prescriber subdermally
☐ Z30.017 ☐ Z30.46 ☐ Other: _____ Date of Last Menses: _____ Anticipated Date of Insertion: _____

_____ _____
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 Signature: _____ Date: _____

Merck Sharp & Dohme Corp. ("Merck"), a subsidiary of Merck & Co., Inc., has retained Lash Group ("Lash") a subsidiary of AmerisourceBergen, a supplier of reimbursement support services, to support the Customer Support Center for NEXPLANON. 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 you by Lash, providing reimbursement assistance services for Merck products pursuant to an agreement with Merck, in response to your request for insurance coverage information regarding your patient. The information provided will be based on statements of individuals not affiliated with Lash, the Customer Support Center for NEXPLANON, or Merck. Neither Lash, the Customer Support Center for NEXPLANON, 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 you in response to this request is intended for your and your 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.

Patient Authorization

(For benefit investigation request only)

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, they will need to obtain, review, use, and disclose my personal health information (PHI), including information relating to my medical condition and information on my request form, and any prescription. I authorize my physician, pharmacy(ies), and my health plan(s) to disclose my PHI to Lash and their administrators as necessary to complete the insurance investigation process. I further authorize Lash and their administrators to use my PHI with Specialty Pharmacies (Accredo or CVS Health) to provide services 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 to coordinate the delivery, receipt, and storage of my NEXPLANON® (etonogestrel implant) 68 mg radiopaque prescription medication for the sole purpose of administration by my prescribing provider. The prescribing provider listed above is my health care agent who administers NEXPLANON at his/her medical facility.

I agree to allow the Specialty Pharmacy to contact me via mail, telephone, or email in connection with carrying out these services. I understand that my name, address, and any other personal identifying information provided in my request form will be available to the Specialty Pharmacy and their affiliates. I understand that my PHI disclosed under this request may no longer be protected by privacy laws and may be re-disclosed by the recipient, but that Lash and its administrators have agreed to use my PHI only for the purposes described herein. I also understand that non-identifiable information concerning individuals requesting assistance with insurance coverage may be summarized for statistical or other purposes and provided to Merck by the Specialty Pharmacy, but my identity will not be determinable from such summary information.

I understand that if I do not provide an Authorization, I will not be able to obtain services 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. The cancellation will not apply to any information already used or disclosed pursuant to this Authorization.

If I do not cancel this Authorization, the Authorization will expire 15 months from the date signed below. Merck has retained Lash and the Specialty Pharmacies to provide services to customers, including reimbursement services. 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.

In order for the Specialty Pharmacy to ship my NEXPLANON prescription medication directly to my prescribing provider, I hereby authorize the Specialty Pharmacy to contact my prescribing provider to coordinate the delivery, receipt, and storage of my NEXPLANON prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment.

Patient Signature: _____ **Date:** _____

Print Name: _____ **Date:** _____

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

Please note that the patient signature is required to conduct a Benefit Investigation.

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

NEXT STEP:

Coverage Under the Pharmacy Benefit

After the benefit investigation has been completed, a Benefit Summary Form will be faxed to your office with available coverage information. If coverage is available under the patient's pharmacy benefit and you would like to proceed with a prescription, please check the Prescription Order box under Fulfillment Options at the top of page 1 of this Direct Service Request Form and fax it to the Customer Support Center for NEXPLANON at 844-232-2618. The prescription will then be forwarded to the Specialty Pharmacy you selected or to the Specialty Pharmacy required by the insurance plan. The Specialty Pharmacies are Accredo and CVS Health.

Coverage Under the Medical Benefit

If coverage is available under the patient's medical benefit and you would like to purchase NEXPLANON, please contact one of our Specialty Distributors: Curascript (866-844-0148) or Theracom (866-318-3492).

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MERCK