

## 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 Pharmacy, AllianceRx Walgreens Prime, Cigna Specialty Pharmacy Services, CVS Health Pharmacy, Humana Specialty Pharmacy or Magellan Rx Pharmacy) 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 certain 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:** \_\_\_\_\_

**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 Pharmacy, AllianceRx Walgreens Prime, Cigna Specialty Pharmacy Services, CVS Health Pharmacy, Humana Specialty Pharmacy or Magellan Rx Pharmacy.

#### 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).

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.



Kyleena<sup>®</sup>  
(levonorgestrel-releasing  
intrauterine system) 19.5 mg

Mirena<sup>®</sup>  
(levonorgestrel-releasing  
intrauterine system) 52 mg

Skyla<sup>®</sup>  
(levonorgestrel-releasing  
intrauterine system) 13.5 mg



#### Patient Authorization

I authorize the use and/or disclosure of my private health information, described below, which may include "Protected Health Information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). In general terms, I understand that Protected Health Information is health information that identifies me or that could reasonably be used to identify me. I understand that this authorization is voluntary.

I authorize my healthcare providers, including my physicians, pharmacies, and my health plan insurers to share my name, address, and phone number along with my prescription, medical diagnosis, treatment, and insurance information with Bayer and its agents and contractors. These agents include a company that provides reports to Bayer on sales of Kyleena<sup>™</sup>, Mirena<sup>®</sup> and Skyla<sup>®</sup> and a company that provides quality control and checks the accuracy of reports on sales of Kyleena, Mirena or Skyla (collectively "Bayer").

I understand that certain healthcare providers, such as my pharmacies, may receive payment from Bayer in connection with the disclosure of my PHI as described in this authorization.

I allow the use of my PHI and the sharing of my PHI to: 1) communicate with me, my healthcare providers, and health plans about my medical care, including treatment with Kyleena, Mirena or Skyla; 2) provide information on coverage and reimbursement of Kyleena, Mirena or Skyla to me and my healthcare providers; 3) facilitate returns of Kyleena, Mirena or Skyla; 4) be used for sales purposes, including to evaluate healthcare provider prescribing patterns; and 5) comply with applicable law.

I understand that any personal information provided on this form will not be used for any purposes other than those described above unless I give written consent, or it is required or permitted under the law, and my name and all other identifying information is removed.

This authorization will remain in effect for 1 year after the date I sign it and will expire after 1 year unless I revoke it prior to this time. I can withdraw (ie, take back) this authorization earlier by sending a written request to Bayer Healthcare Pharmaceuticals, Attn: Medical Communications, 100 Bayer Boulevard, Whippany, NJ 07981 (Fax# 973-305-3560), except to the extent my healthcare provider or health plan has taken action in reliance on my authorization. I understand that if I revoke this authorization, it will not have any effect on any actions my healthcare providers or my health plan may have taken before receiving the revocation, and will not affect Bayer's ability to use and disclose any information it has already received.

I also understand that persons or entities that receive my PHI under this authorization may not be required by privacy laws (such as the HIPAA Privacy Rule) to protect the information and may share it with others without my permission, if permitted by laws applicable to them.

I may refuse to sign this form, and refusal will not affect my treatment, payment for treatment, enrollment in a health plan, or eligibility for benefits.

I have read this entire authorization and/or had its contents read to me. I have had an opportunity to ask questions about the uses and disclosures of PHI described above, and all of my questions have been answered to my satisfaction. I authorize the use and disclosure of my information as described in this form. I understand that I am entitled to receive a signed copy of this authorization.

Printed name of Individual or Individual's representative

Date

Signature of Individual or Individual's representative

Date

If signed by the Individual's representative, a description of the representative's relationship to the Individual and such person's authority to act for the Individual (eg, parent, guardian, etc)

**PLEASE FAX THE PRESCRIPTION REQUEST FORM, INCLUDING THE SIGNED PATIENT AUTHORIZATION SECTION ON THIS PAGE.**

**Please see Important Safety Information for Kyleena, Mirena or Skyla on third page and accompanying full Prescribing Information for Kyleena, Mirena and Skyla.**



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