

Select Choice of Specialty Pharmacies

Specialty Pharmacy	Fax	Phone	Hours of Operation
<input type="checkbox"/> CVS Caremark (In the Continental US)	(866) 216-1681	(866) 638-8312	8:30 AM - 8:30 PM ET
<input type="checkbox"/> CVS Caremark (In Hawaii-Neighbor Islands)	(877) 232-5455	(800) 896-1464	8:30 AM - 8:30 PM HT
<input type="checkbox"/> CVS Caremark (In Hawaii-Oahu)	(808) 254-4445	(808) 254-2727	8:30 AM - 8:30 PM HT
<input type="checkbox"/> Prime Therapeutics	(877) 684-8854	(855) 457-0170	8:00 AM - 8:00 PM ET
<input type="checkbox"/> Walgreens	(800) 830-5292	(877) 686-4633	8:00 AM - 8:00 PM ET
<input type="checkbox"/> Cigna Specialty Pharmacy Services	(800) 351-3616	(800) 351-3606	6:00 AM - 12:00 AM ET
<input type="checkbox"/> Humana Specialty Pharmacy	(877) 405-7940	(800) 486-2668	8:00 AM - 8:00 PM ET
<input type="checkbox"/> Skyemed Pharmacy & Infusion Services (Tricare)	(800) 432-6614	(866) 778-8255	7:00 AM - 7:00 PM ET

Patient Information

Last Name: _____ First Name: _____ MI: _____ DOB: _____
 Address: _____ City: _____ State: _____ ZIP Code: _____
 Phone: _____ Alternate Phone: _____ Primary Language: _____ Gender: _____

Prescription Information

By submitting this prescription request form, prescriber and patient are aware that the Specialty Pharmacy will ship upon verification of benefits and collection of applicable co-pay. If there is a zero-dollar co-pay, patient may not be contacted. The Specialty Pharmacy will ship to prescriber's office, and will not contact prescriber before shipping.

Rx Skyla[®]

Skyla ICD-9 (ICD-10): V25.11 (Z30.430)
 Other (List ICD-9 or ICD-10): _____
 SIG: To be inserted one time by prescriber. Route intrauterine
 Quantity: 1
 • Date of last menses: _____
 • List Allergies: _____
 • Requested Date of Delivery: _____
 • Scheduled Insertion Date: _____
 • **Product Substitution Permitted (Signature) _____ Date _____**

Dispense as Written (Signature) _____ Date _____
 • I have previously received an IUS Educational Kit Yes
 • I would like to receive an IUS Educational Kit Yes
 • For ARNP, NP, and PA, collaborative physician agreement is with: _____

Rx Mirena[®]

Mirena ICD-9 (ICD-10): V25.11 (Z30.430) 626.2 (N92.0) 627.0 (N92.4)
 Other (List ICD-9 or ICD-10): _____
 SIG: To be inserted one time by prescriber. Route intrauterine
 Quantity: 1
 • Date of last menses: _____
 • List Allergies: _____
 • Requested Date of Delivery: _____
 • Scheduled Insertion Date: _____
 • **Product Substitution Permitted (Signature) _____ Date _____**

Dispense as Written (Signature) _____ Date _____
 • I have previously received an IUS Educational Kit Yes
 • I would like to receive an IUS Educational Kit Yes
 • For ARNP, NP, and PA, collaborative physician agreement is with: _____

Prescriber Information

Prescriber Name (Last, First): _____ Title (please check one) MD DO NP PA
 Office Contact: _____ Phone: _____ Fax: _____
 Address: _____ City: _____ State: _____ ZIP Code: _____
 Ship to address if different from above: _____ DEA #: _____
 Group or Hospital: _____ Physician Medicaid #: _____ License #: _____ NPI #: _____
 If covered through Buy and Bill, Physician will accept Buy and Bill coverage.

Patient Insurance Information

(Please copy and attach the front and back of medical and prescription insurance cards - Send with request)

Patient has no insurance and/or does not want insurance billed. Request self-pay option
 Prescription Insurance: _____ Medical Insurance: _____
 Phone: _____ Phone: _____
 Subscriber #: _____ Group #: _____ Subscriber #: _____ Group #: _____
 Policy Holder Information (if different from patient) Policy Holder Information (if different from patient)
 Name: _____ Employer: _____ Name: _____ Employer: _____
 Relation to Patient: _____ Relation to Patient: _____

PLEASE FAX THE PRESCRIPTION REQUEST FORM, INCLUDING THE SIGNED PATIENT AUTHORIZATION SECTION ON PAGE 3.

Please see Important Safety Information for Skyla and Mirena on next page and accompanying full Prescribing Information for [Skyla](#) and [Mirena](#). www.WHCSupport.com



The Specialty Pharmacy Program prescription process

To order Skyla® or Mirena®, complete the Specialty Pharmacy Prescription Request Form as follows:

1. Select Specialty Pharmacy.
2. Enter the patient and prescriber information in the space provided on the Specialty Pharmacy Prescription Request Form, including the patient's pharmacy drug benefit and medical insurance information.
 - Please ensure that all information is complete
 - Include copies of the patient's pharmacy benefit and medical insurance cards
 - Prescriber information (complete this information and then photocopy the form for future use)
3. Complete the prescription section.
 - Indicate if Skyla or Mirena will be administered
 - Indicate appropriate diagnosis code
 - Sign the prescription
 - For ARNP, NP, and PA, identify who your collaborative agreement is with if requested to write prescriptions in your state
4. Have the patient read and sign the Patient Authorization section of the form and fax it to the appropriate SP with the SP request form.
5. Finalize the prescription request and prepare for your patient's Skyla or Mirena insertion.
 - a. Fax the completed Prescription Form, including the Patient Authorization section, to either CVS Caremark (Continental US 1-866-216-1681; Hawaii -Neighborhood Islands 1-877-232-5455; Hawaii-Oahu 1-808-254-4445), Walgreens (1-800-830-5292), or Prime Therapeutics (1-877-684-8854). For questions call 1-866-638-8312 for CVS Caremark in the Continental US, 1-800-896-1464 in Hawaii-Neighborhood Islands, and 1-808-254-2727 in Hawaii-Oahu; 1-877-686-4633 for Walgreens; and 1-855-457-0170 for Prime Therapeutics.
 - b. Bill the patient's insurance for the procedure and your customary professional services charges only.

To find out more about the Specialty Pharmacy Program or to request prescription forms, contact your Bayer Sales Consultant or visit our website at www.whcsupport.com for more information.

Indication for Skyla®

Skyla is indicated for the prevention of pregnancy for up to 3 years. Skyla should be replaced after 3 years if continued use is desired.

Indications for Mirena®

Mirena is indicated for intrauterine contraception for up to 5 years. Mirena is also indicated to treat heavy menstrual bleeding in women who choose to use intrauterine contraception as their method of contraception. Mirena is recommended for women who have had a child. Mirena should be replaced after 5 years if continued use is desired.

IMPORTANT SAFETY INFORMATION ABOUT SKYLA AND MIRENA

Who is not appropriate for Skyla and Mirena

Use of Skyla or Mirena is contraindicated in women with: known or suspected pregnancy and cannot be used for post-coital contraception; congenital or acquired uterine anomaly, including fibroids if they distort the uterine cavity; known or suspected breast cancer or other progestin-sensitive cancer, now or in the past; known or suspected uterine or cervical neoplasia; liver disease, including tumors; untreated acute cervicitis or vaginitis, including lower genital tract infections (eg, bacterial vaginosis) until infection is controlled; postpartum endometritis or infected abortion in the past 3 months; unexplained uterine bleeding; current IUD; acute pelvic inflammatory disease (PID) or history of PID (except with later intrauterine pregnancy); conditions increasing susceptibility to pelvic infection; or hypersensitivity to any component of Skyla or Mirena.

Clinical considerations for use and removal of Skyla and Mirena

Use Skyla or Mirena with caution after careful assessment in patients with coagulopathy or taking anticoagulants; migraine, focal migraine with asymmetrical visual loss, or other symptoms indicating transient cerebral ischemia; exceptionally severe headache; marked increase of blood pressure; or severe arterial disease such as stroke or myocardial infarction. Consider removing the intrauterine system if these or the following arise during use: uterine or cervical malignancy or jaundice. If Skyla or Mirena is displaced (e.g., expelled or perforated the uterus), remove it.

In addition, Skyla can be safely scanned with MRI only under specific conditions.

Pregnancy related risks with Skyla and Mirena

If pregnancy should occur with Skyla or Mirena in place, remove the intrauterine system because leaving it in place may increase the risk of spontaneous abortion and preterm labor. Removal or manipulation may result in pregnancy loss. Evaluate women for ectopic pregnancy because the likelihood of a pregnancy being ectopic is increased with Skyla or Mirena. Tell women about the signs of ectopic pregnancy and associated risks, including loss of fertility. Women with a history of ectopic pregnancy, tubal surgery, or pelvic infection carry a higher risk of ectopic pregnancy.

Educate her about PID

IUDs have been associated with an increased risk of PID, most likely due to organisms being introduced into the uterus during insertion. Inform women about the possibility of PID and that PID can cause tubal damage leading to ectopic pregnancy or infertility, or infrequently can necessitate hysterectomy, or cause death. PID is often associated with sexually transmitted infections (STIs); Skyla and Mirena do not protect against STIs, including HIV.

In clinical trials with:

- Skyla – PID occurred more frequently within the first year and most often within the first month after insertion.
- Mirena – upper genital infections, including PID, occurred more frequently within the first year. In a clinical trial with other IUDs and a clinical trial with an IUD similar to Mirena, the highest rate occurred within the first month after insertion.

Expect changes in bleeding patterns with Skyla and Mirena

Spotting and irregular or heavy bleeding may occur during the first 3 to 6 months. Periods may become shorter and/or lighter thereafter. Cycles may remain irregular, become infrequent, or even cease. Consider pregnancy if menstruation does not occur within 6 weeks of the onset of previous menstruation.

Be aware of other serious complications and most common adverse reactions

Some serious complications with IUDs like Skyla and Mirena are expulsion, sepsis, and perforation. Perforation may reduce contraceptive efficacy. The risk of perforation is higher if inserted in lactating women and may be higher if inserted in women who are postpartum or when the uterus is fixed retroverted.

Ovarian cysts may occur and are generally asymptomatic, but may be accompanied by pelvic pain or dyspareunia. Evaluate persistent enlarged ovarian cysts.

In clinical trials with:

- Skyla – the most common adverse reactions ($\geq 5\%$ users) were vulvovaginitis (20.2%), abdominal/pelvic pain (18.9%), acne/seborrhea (15.0%), ovarian cyst (13.2%), headache (12.4%), dysmenorrhea (8.6%), breast pain/discomfort (8.6%), increased bleeding (7.8%), and nausea (5.5%).
- Mirena – adverse reactions reported in $\geq 5\%$ of users were alterations of menstrual bleeding patterns [including unscheduled uterine bleeding (31.9%), decreased uterine bleeding (23.4%), and increased uterine bleeding (11.9%)], abdominal/pelvic pain (22.6%), amenorrhea (18.4%), headache/migraine (16.3%), genital discharge (14.9%), vulvovaginitis (10.5%), breast pain (8.5%), back pain (7.9%), benign ovarian cyst and associated complications (7.5%), acne (6.8%), dysmenorrhea (6.4%), and depression/depressive mood (6.4%).

Teach patients to recognize and immediately report signs or symptoms of the aforementioned conditions. Evaluate patients 4 to 6 weeks after insertion of Skyla or Mirena and then yearly or more often if clinically indicated.

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 Skyla and Mirena and a company that provides quality control and checks the accuracy of reports on sales of Skyla and Mirena (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 Skyla or Mirena; 2) provide information on coverage and reimbursement of Skyla or Mirena to me and my healthcare providers; 3) facilitate returns of Skyla or Mirena; 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 Skyla and Mirena on second page and accompanying full Prescribing Information for [Skyla](#) and [Mirena](#).

www.WHCSupport.com



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