

### Physician Information

\_\_\_\_\_  
 Prescriber's Name

\_\_\_\_\_  
 Contact Name

\_\_\_\_\_  
 Name of Practice/Clinic/Institution

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City/State/ZIP

\_\_\_\_\_  
 Phone

\_\_\_\_\_  
 Fax

\_\_\_\_\_  
 E-mail

\_\_\_\_\_  
 State Medical License #

\_\_\_\_\_  
 DEA #

\_\_\_\_\_  
 UPIN #

### Prescription Information for Mirena®

**Rx Mirena® (levonorgestrel-releasing intrauterine system)**

Dispense \_\_\_ Mirena®      SIG: To be inserted by physician as directed      Refills \_\_\_

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Date

### Patient Information

\_\_\_\_\_  
 Patient's Name

\_\_\_\_\_  
 SS #

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Home Address

\_\_\_\_\_  
 City

\_\_\_\_\_  
 State

\_\_\_\_\_  
 ZIP

\_\_\_\_\_  
 Home Phone

\_\_\_\_\_  
 Work Phone

Preferred Phone:  Home  Work      Okay to leave a message at home:  Yes  No      At work:  Yes  No

\_\_\_\_\_  
 E-mail

\_\_\_\_\_  
 Allergies

### Credit Card Information

Credit Card:     American Express®     Discover®     MasterCard®     VISA®

Please select payment option:     One payment in full     4-payment installment plan     12-payment installment plan

\_\_\_\_\_  
 Card Number

\_\_\_\_\_  
 Exp Date

\_\_\_\_\_  
 Cardholder's Signature

\_\_\_\_\_  
 Date

### Patient Authorization

- I acknowledge that items purchased are nonreturnable.
- I acknowledge that a photocopy or facsimile of this form is valid as the original.
- I authorize my credit card to be billed in full at the time of purchase or in monthly payments according to the credit card payment plan.
- I authorize my physician to provide my name and the information on this form to representatives of the Mirena® Reimbursement Support Program in order to facilitate the securing of Mirena®. I hereby authorize representatives of the Mirena® Reimbursement Support Program to contact my doctor on my behalf for the release of medical and prescription information that is to be used in the dispensing of my Mirena®. I direct that this authorization be treated as permanent authorization for release of my information unless I otherwise notify the Mirena® Reimbursement Support Program in writing.

\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date

## When Mirena<sup>®</sup> is covered by a pharmacy benefit plan:

- The healthcare provider must fax the Mirena<sup>®</sup> prescription form on the reverse side of this page to the Mirena<sup>®</sup> Support Center **(1-888-281-8199)**
- The patient must call the Mirena<sup>®</sup> Support Center **(1-866-647-3646)** and make a co-payment before the unit can be released for shipment

## When Mirena<sup>®</sup> is not covered by any benefit plan:

- Women may choose from 3 payment\* options:
  - **1 payment of \$585.89**
  - **4 monthly payments** (first payment of \$234.35; 3 additional payments of \$117.18)
  - **12 monthly payments of \$50.77** (total cost of \$609.24)
- The healthcare provider must fax the Mirena<sup>®</sup> prescription form on the reverse side of this page to the Mirena<sup>®</sup> Support Center **(1-888-281-8199)** indicating the credit card information and the payment option selected
- The patient must call the Mirena<sup>®</sup> Support Center **(1-866-647-3646)** to verify this payment information before the unit can be released for shipment

**Upon payment, Mirena<sup>®</sup> will be shipped to the office of the healthcare provider with the patient's name on the prescription label.**

\*Prices subject to change.