



45 Earhart Drive, Suite 110, Amherst, NY 14221

IMPLANON™ AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name		First Name		Today's Date		Date Needed	
Parent/Guardian				Prescriber		Hospital/Clinic	
Home Phone Number () ()		Work Phone Number () ()		Phone Number () ()		Fax Number () ()	
Home Address		City State Zip		Address		City State Zip	
Ship To: <input type="checkbox"/> Prescriber <input type="checkbox"/> Patient's Home				Office Contact		Prescriber Speciality	
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other				Contact Preference <input type="checkbox"/> Phone <input type="checkbox"/> Fax			
Known Allergies:				<input type="checkbox"/> Email: _____			
Weight _____ Lbs.		Height _____ Ft _____ In		Date of Birth ____/____/____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
				Special Instructions			

INSURANCE INFORMATION	DRUG NAME: IMPLANON™
Fill out entirely or fax a copy of patient's insurance card (both sides):	<input type="checkbox"/> New Authorization <input type="checkbox"/> Re-authorization*
Primary Insurance: _____	Dose: _____
Name of Insured: _____	Frequency: _____
Policy #: _____	
Group #: _____	
Phone #: _____	
Rx Drug Card #: _____	
Secondary Insurance: _____	
Name of Insured: _____	
Policy #: _____	
Group #: _____	
Phone #: _____	
Rx Drug Card #: _____	
STATEMENT OF MEDICAL NECESSITY	
Primary Diagnosis: _____	
ICD9 Code: _____	
Estimated Start of Therapy: _____	