OSPHENA AT HOME®
BONJESTA AT HOME®

Women's health home delivery service with specialized support provided by licensed pharmacists with a dedicated customer service staff

Powered by *ProCare Pharmacy Care*

CONVENIENCE FOR YOUR OFFICE:

- Verification of patient benefits
- Assistance with prior authorizations
- Monthly refill reminders for patients
- Three easy ways to submit your prescriptions: fax, call or ePrescribe

CONVENIENCE FOR YOUR PATIENTS:

- FREE discreet home delivery*
- Pharmacists to answer product questions
- Insurance benefit verification
- Monthly refill reminders
- Prior authorization support

COMMERCIALLY INSURED PATIENTS

pay as little as **$0**

OSPHENA AT HOME®

Cash patients can pay:

- **30 tablets for $40**
- **90 tablets for $80**

BONJESTA AT HOME®

Cash patients can pay:

- **30 tablets for $40**
- **60 tablets for $60**

If you choose to ePrescribe, select *ProCare Pharmacy Care*

Not listed in your software program? See below to conduct a system search:

1. Select "**Retail**" pharmacy as opposed to "Mail Order" pharmacy to do your search if that is an option.
2. Most ePrescribing systems have a search library. Begin by using the following criteria only:
   - "***ProCare Pharmacy Care***"
   - "**Miramar, Florida 33025**"
   - "**NCPDP# 1098121**"
3. If ***ProCare Pharmacy Care*** does not show in the system, add the following criteria:
   - NCPDP # 1098121
   - Address: 3891 Commerce Parkway Miramar, FL 33025
   - If NPI# is required: 1427160357
   - If you are still not able to find ***ProCare Pharmacy Care***, contact your ePrescribing software vendor and log a case to have the pharmacy added to your system.

PLEASE SEE REVERSE FOR ORDERING INSTRUCTIONS

For questions or to submit a prescription, please call 844-716-HOME (4663)

*Minimum purchase required. Additional shipping charges may apply.

Home Delivery Prescriber FAX Form | FAX 844-375-3010 | Phone 844-716-HOME (4663)

INSURANCE INFORMATION

☐ **Rx not covered by insurance? Process as cash**

☐ **Rx is covered by insurance? Complete all sections of form below**

1. PATIENT INFORMATION

Last Name		First Name		Middle initial
Delivery Address				APT #
City	State	ZIP	Email address	
Gender ☐ Female ☐ Male	Date of Birth (mm/dd/yyyy)	☐ Spanish speaking		
Rx Insurance Provider	Member ID#	Group ID#	Rx BIN#	
Best time to contact : ☐ AM ☐ PM	Preferred phone number		Cell phone	

— PRESCRIBER IS REQUIRED TO ATTACH COPY OF THE FRONT AND BACK OF RX INSURANCE CARD —

BONJESTA AT HOME®*

Quantity ☐ 30 ☐ 60 ☐ ________

Refills ________

OSPHENA AT HOME®

Quantity ☐ 30 ☐ 90 ☐ ________

Refills ________

***Minimum purchase required. Additional shipping charges may apply.**

2. PRESCRIBER AND PRESCRIPTION INFORMATION – to be completed by prescriber

– or –

Attach your office prescription to the lower half of this form,

– or –

ePrescribe to
ProCare Pharmacy Care
Miramar, FL 33025

Health care information is personal and sensitive information. This communication and any attachments are intended solely for the use of *ProCare Pharmacy Care* and contain confidential and legally privileged information. If you are not the intended recipient, any dissemination, distribution or copying is strictly prohibited. If you received this communication in error, please notify *ProCare Pharmacy Care* by FAX or phone immediately.

Notes to Pharmacy/Dosing Instructions		
Prescriber Name		
NPI#	Office Contact Name	
Prescriber Phone	Prescriber FAX	
Prescriber Address		
City	State	ZIP
PRESCRIBER SIGNATURE		Date

Please sign this form if you authorize pharmacy to process and manage, on your behalf, Prior Authorization requests as permitted by the payer including but not limited to any appeals of denial. By doing so, pharmacy will be your designated agent, to use and disclose any information, required in the prior authorization forms, and requested by patient's insurer. By signing this form, you certify that you have obtained all necessary consent from the patient to obtain and disclose any information about the patient, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for your payment and/or healthcare operation purposes. As your designated agent, pharmacy is required to comply with, and agrees that it will comply with the applicable requirements of 45 CFR 164.504(e) regarding designated agents, and that it will safeguard any protected health information that it obtains on your behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

PRIOR AUTHORIZATION SIGNATURE	Date

3. PRESCRIBER — FAX completed form to 844-375-3010

DUCHESNAY USA

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