



IUD NOTIFICATION FORM

Please fax this form to Peach State Pharmacy Department at 1-866-374-1579

Patient Name: _____ Patient ID: _____

Patient DOB: _____ Type of IUD (circle one): Mirena (J7302) or ParaGard (J7300)

You must provide the IUD from your office stock and bill for the IUD with the insertion.

- If your office does not stock IUDs, then you may purchase them directly from Caremark. Please call Caremark at (p) 866-647-3646 (f) 888-281-8199 or online at www.mirenasupport.com
• Do not contact Caremark if you already have the IUD in stock.

IUD Checklist

Peach State Health Plan (Peach State) requires notification before insertion of an IUD in order to ensure payment. We have provided this checklist based on the FDA recommendations to help determine whether or not your patient may be a good candidate for an IUD.

Please check all that apply to the patient:

- Is Pregnant
Has current or recent pelvic inflammatory disease (within 12 months)
Has current or recent post-abortion sepsis (within 12 months)
Has current or recent STD (within 2 years)
Has purulent cervicitis
Has undiagnosed abnormal vaginal bleeding
Has an allergy to any component of the IUD
Has Wilson's disease (for copper IUDs)
Is high risk for acquiring STDs
Has anatomic abnormalities including bicornuate uterus, cervical stenosis, or fibroids
Has known or suspected gynecologic neoplasia
Has an abnormal Pap smear or cervical neoplasia
Has a prior history of Essure or tubal ligation
Has a history of IUD insertion and discontinuation within a 3 year period
Has had previous adverse effects from progesteron

If any of the above are marked, please explain and include documentation:

If the patient meets any of the above conditions then an IUD would NOT be recommended because of the probability of a poor outcome.

None of the above apply to this patient

You will not be paid for the IUD or the placement unless the prior notification form is completed, returned to Peach State, and a reference number is issued prior to the date of service. You will receive fax notification upon receipt. If you have any questions regarding this process, please call (800)514-0083 option 2.

Provider Name: _____ Contact Person: _____
Office Phone Number: _____ Fax Number: _____
Anticipated Date of Service: _____ Place of Service/Practice Name: _____