

# Replacement Authorization Request Form for ANNOVERA® (segesterone acetate and ethinyl estradiol vaginal system)

A complete Replacement Authorization (RA) Request Form, signed by you and your prescribing healthcare provider, is required for all ANNOVERA replacement requests. Your replacement request must comply with the ANNOVERA Replacement Program Terms, Conditions, and Eligibility Criteria, set forth on page 3.

RA Request Forms must be submitted to vitaCare<sup>SM</sup> Customer Service:  
Phone: **800-350-3819** | Fax: **800-891-4320**  
Email: **CustomerService@vitaCareRx.com**

Patient Information	
Patient Name (First, Last)	
Address	
Email Address	Phone Number
Prescriber Name (First, Last)	

## Reason for replacement (Check one)

- Lost
- Damaged (If damaged, please provide a brief explanation of how it was damaged)

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Date product was lost or damaged: \_\_\_\_\_

**Please provide Proof of Purchase** (If you do not have a copy of your prescription purchase receipt, you can obtain one from your prescription insurance provider or the pharmacy that dispensed your ANNOVERA prescription).

I certify and declare under penalty of perjury that the information provided in this form is complete, true, and correct. I agree to notify TherapeuticsMD of any changes I become aware of that could affect the review and consideration of this replacement request.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## PRESCRIPTION FORM

### Patient Information

_____ Patient Name (First, Last)	_____ Phone Number	
_____ Date of Birth	_____ Email	
_____ Address		
_____ City	_____ State	_____ ZIP Code

### Prescriber Information *(healthcare provider to complete)*

_____ Prescriber Name (First, Last)	
_____ Phone Number	_____ Fax Number
_____ NPI Number	

### Prescription Information *(to be filled out by healthcare provider)*

**ANNOVERA<sup>®</sup> (segesterone acetate and ethinyl estradiol vaginal system)**

**PRODUCT BILLING CODE:** 50261-0313-01

**SIG:** ANNOVERA should be placed into the vagina for 21 days then removed for 7 days of each cycle, for up to 13 cycles

Each **ANNOVERA** is designed to be used for up to 13 cycles (1 year) when left in place 21 days and removed 7 days per cycle

Each box contains 1 **ANNOVERA** vaginal system in a pouch and 1 storage case.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Processing and fulfillment of prescription may be completed by vitaCare Prescription Services or transferred to another pharmacy based on patient's insurance and filling preference.

Important Confidentiality Notice: This fax may contain confidential health information. This information is intended for the use of the individual entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken on the content of this document is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of this document.

# **ANNOVERA® (segesterone acetate and ethinyl estradiol vaginal system) Replacement Program Terms, Conditions, and Eligibility Criteria**

TherapeuticsMD, Inc. is committed to excellence in customer service and satisfaction, and offers a one-time replacement against loss or damage of ANNOVERA (segesterone acetate and ethinyl estradiol vaginal system) (“ANNOVERA system”). For questions about this program, please call 800-350-3819.

This ANNOVERA Replacement Program (“Program”) is made available under the following terms, conditions, and eligibility criteria:

1. Patient must have purchased (directly or through insurance) an ANNOVERA system under a valid prescription at a licensed U.S. pharmacy.
2. The patient’s ANNOVERA system was lost or damaged within twelve (12) months of receipt of such product by the patient. Replacement of an ANNOVERA system is available for loss or damage only, and does not include product quality complaints, such as a product defect. If an ANNOVERA system is defective, please call vitaCare Prescription Services at 800-350-3819 to report the complaint and follow the TherapeuticsMD Return Policy.
3. Patient has not previously received a replacement for the ANNOVERA system under this Program. This Program is limited to only one (1) replacement ANNOVERA system per patient, regardless of the number of ANNOVERA systems the patient has received or used in her lifetime.
4. A Replacement Authorization Request Form for ANNOVERA (including the Prescription Form) must be completed and signed by the patient and a prescribing healthcare provider, and submitted by fax or email to vitaCare Prescription Services (“vitaCare”) within thirty (30) days of the date of loss or damage of the ANNOVERA system. The form may be requested from vitaCare by phone, fax, or email, or by visiting [vitacarerx.com/annovera-replacement](http://vitacarerx.com/annovera-replacement).

## **vitaCare Prescription Services**

**Phone:** 800-350-3819

**Fax:** 800-891-4320

**Email:** [CustomerService@vitaCareRx.com](mailto:CustomerService@vitaCareRx.com)

5. Upon receipt and approval of a complete and signed Replacement Authorization Request Form for ANNOVERA, vitaCare will ship a replacement ANNOVERA system directly to the patient.
6. By submitting a Replacement Authorization Request Form for ANNOVERA, the patient and prescribing healthcare provider acknowledge that the patient is an eligible patient and each understands and agrees to comply with the terms and conditions of this Program.
7. TherapeuticsMD reserves the right to amend or end this program at any time without notice.

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