Commercial Coverage Assurance Program for NEXPLANON - Rebate Request Form

Effective February 1, 2024

Nexplanon®
(etonogestrel implant) 68mg
Radiopaque

ORGANON

Program Description and Eligibility:	Customers with inventory of NEXPLANON purchased **February 1, 2024 through October 31, 2024**, that is subsequently reimbursed by a **commercial payer** at less than the customer's net acquisition cost, are eligible to participate in the program. For each unit of NEXPLANON that is under-reimbursed for patient dates of service from **February 1, 2024 through October 31, 2024**, customers may receive a rebate up to the difference between the customer's net acquisition cost for the unit and the documented payer reimbursement allowable. **This program is only available to customers purchasing NEXPLANON at wholesale acquisition cost (WAC).** Rebate allowable is the total provider reimbursement for that unit, including any patient cost share. Customers will not be required to sign a contract to participate in the program. Please note that the maximum possible rebate amount is $200.00 per unit. **This program does not apply to any reimbursement received from state or federal healthcare programs, such as Medicaid, Managed Medicaid, TRICARE, or Medicare.**
Rebate Request Form Submission Instructions:	Provide information for each unit of NEXPLANON for which you are requesting a rebate on the attached Rebate Request Form. You may submit requests for multiple units on the same form, and attach additional pages as needed. Submit the Rebate Request Form for NEXPLANON (refer to next page) to Organon's service provider, HCL, with copies of: (1) Distributor Invoice (2) The de-identified paid claim/Explanation of Benefits (EOB) for each unit that was under-reimbursed. **PLEASE REMOVE/BLACKOUT** all Patient Health Information (PHI) to maintain HIPAA compliance. The latest date to submit a rebate request to Organon's service provider, HCL, is December 31, 2024. Be sure to sign the Rebate Request Form before submitting. Two ways to submit the attached form and supporting documentation: 1. E-mail to: CCAPN-Rebate@hcl.com 2. Fax to: 800-259-5458 Please allow up to 6 weeks for processing after a completed Rebate Request Form has been submitted. If information is missing from the submitted Rebate Request Form, an HCL (Organon's service provider) representative will contact you to obtain the missing information. Rebate checks will be made payable to the location provided on the form.
Reporting Requirements:	Customers who receive reimbursement under this program must comply with all federal and state healthcare program reporting and disclosure rules for discounts and rebates.
Questions:	If you have questions about how to fill out the Rebate Request Form, or you want to check the status of a submitted request, please contact HCL (Organon's service provider) at 800-561-5484 for assistance.

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Location Name:			
Location Address:			
Location City/ State/ZIP Code:	City:	State:	ZIP:
Provider Name:			
Office Contact Person and Title:			
Office Contact Phone Number:			
Office Contact Email Address:			

☐ Check box if check is to be sent to a different location:

Address:_____

City:_____ State:_____ ZIP:_____

By participating in this program, you consent to HCL (Organon's service provider) reaching out to you if additional information is needed.

By signing below, I certify that the information provided on this form and any attachments is accurate. I also certify that I am not requesting a rebate for units provided to patients covered by a government health benefit program. I will also not seek further reimbursement from the plan or patient for units listed on this form.

Signature:_____ Date:_____

Total number of pages submitted with this request, including this one: _____

You may e-mail or fax the completed form and documents.

E-mail to: CCAPN-Rebate@hcl.com

Fax to: 800-259-5458

- ✓ Be sure to include a copy of your Distributor Invoice.
- ✓ For Explanation of Benefits (EOBs), **PLEASE REMOVE/BLACKOUT** all Patient Health Information (PHI) to maintain HIPAA compliance.

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Member/Patient ID number (from EOB)	Patient Date of Service	Total Reimbursement Allowable Amount for J-7307 (NEXPLANON)	Wholesale Acquisition Cost (from Invoice)	Payer Name	Paid Claim/ EOB (insert check mark)
					Attached ☐
					Attached ☐
					Attached ☐
					Attached ☐