



PATIENT ENROLLMENT FORM

\*Required information.



SUPPORT REQUEST	<p><b>Please select one option for Allergan EyeCue® support*:</b>                  (Please note: If no box below is selected, comprehensive support will be provided.)</p> <p><input type="checkbox"/> <b>Comprehensive program support</b> (eg, OZURDEX® benefit verification, prior authorization/appeals support, OZURDEX® Savings Program, information regarding other patient financial support options)</p> <p><input type="checkbox"/> <b>OZURDEX® Savings Program only</b></p>		<p><b>OPTIONAL: By checking the box below, I'm requesting Allergan EyeCue® to enroll my patient in a specialty pharmacy (Note: Specialty pharmacy may not be an option for all insurance plans)</b></p> <p><input type="checkbox"/> <b>Enroll in specialty pharmacy (optional)</b></p>	
	<p>First name*: _____ Middle initial: _____ Last name*: _____</p> <p>Date of birth*: ____/____/____ Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female U.S. resident: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Home phone*: _____ Cell phone: _____ Email: _____</p> <p>Address*: _____ City*: _____ State*: _____ Zip*: _____</p>			
INSURANCE	<p>Patient is uninsured (no third-party or private insurance) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Participating provider <input type="checkbox"/> Nonparticipating provider</p> <p><input type="checkbox"/> Insurance card attached (optional: If patient is insured, provide a legible copy of the front and back of the patient's insurance card)</p>			
	<p><b>Primary Insurance*</b></p> <p><input type="checkbox"/> Commercial <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other</p> <p>Insurance company*: _____</p> <p>Phone*: _____</p> <p>Insured name*: _____</p> <p>Insured date of birth*: _____</p> <p>Policy number*: _____</p>		<p><b>Secondary Insurance</b></p> <p><input type="checkbox"/> Commercial <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other</p> <p>Insurance company: _____</p> <p>Phone: _____</p> <p>Insured name: _____</p> <p>Insured date of birth: _____</p> <p>Policy number: _____</p>	
PRESCRIBING PHYSICIAN	<p>Place of service*: <input type="checkbox"/> Physician's office <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Ambulatory surgical center</p> <p>Practice/facility name*: _____</p> <p>Physician name (first and last)*: _____ Physician specialty: _____</p> <p>Address*: _____ City*: _____ State*: _____ Zip*: _____</p> <p>Email: _____ Phone*: _____ Fax*: _____</p> <p>Facility Tax ID No.*: _____ Physician State License No.*: _____ Physician National Provider Identifier (NPI)*: _____</p>			
	<p><b>Office Contact Information</b></p> <p>Primary office contact*: _____</p> <p>Phone*: _____ Ext: _____ Fax: _____ Email*: _____</p>			
	<p><b>Product: OZURDEX®</b></p> <p>HCPCS code: J7312 Diagnosis 1*: _____</p> <p>CPT® code: 67028 Diagnosis 2: _____</p> <p><b>Please note:</b> We cannot verify benefits without a valid diagnosis code</p>		<p>Drug units*: <input type="checkbox"/> 7 units</p> <p>Anticipated date of treatment: ____/____/____</p>	
	<p><b>IMPORTANT INFORMATION:</b> By submitting this form, you are referring the above patient to Allergan EyeCue® for patient support and to determine eligibility to receive financial support related to OZURDEX®, a product of Allergan, an AbbVie company. By authorizing you to submit this form, the above patient represents that they are an eligible commercially-insured patient and that they will comply with the OZURDEX Savings Program Terms, Conditions, and Eligibility Criteria available and printable at <a href="http://www.OZURDEXSavingsProgram.com/termsandconditions">www.OZURDEXSavingsProgram.com/termsandconditions</a>. AbbVie, its affiliates, collaborators, and agents ("AbbVie") will use the information collected about you and your patient to provide and manage Allergan EyeCue services and the OZURDEX Savings Program and to perform research and analytics on a de-identified basis. For more information about the categories of personal information collected by AbbVie and the purposes for which AbbVie uses personal information, visit <a href="http://www.abbvie.com/privacy">www.abbvie.com/privacy</a>. <b>Please share this information with your patient.</b></p>			

