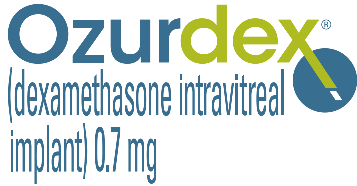


PATIENT ENROLLMENT FORM

*Required information.

SUPPORT REQUEST

Please select one option for *Allergan EyeCue*® support*: (**Please note:** If no box below is selected, comprehensive support will be provided.)

☐ **Comprehensive program support** (eg, benefit verification, prior authorization/appeals support, OZURDEX® Savings Program, information regarding other patient financial support options)

☐ **OZURDEX® Savings Program Only**

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)

☐ **Enroll in specialty pharmacy (optional)**

PATIENT

First name*:______________________ Middle initial:______ Last name*:______________________

Date of birth*:_____/_____/_____ Gender*: ☐ Male ☐ Female U.S. resident: ☐ Yes ☐ No

Home phone*:______________________ Cell phone:______________________ Email:______________________

Address*:______________________ City*:______________________ State*:______ Zip*:______________

INSURANCE

Patient is uninsured (no third-party or private insurance) ☐ Yes ☐ No

☐ Participating provider ☐ Nonparticipating provider

☐ Insurance card attached (optional: If patient is insured, provide a legible copy of the front and back of the patient's insurance card)

Primary Insurance*

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Insurance company*:______________________

Phone*:______________________

Insured name*:______________________

Insured date of birth*:______________________

Policy number*:______________________

Secondary Insurance

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Insurance company:______________________

Phone:______________________

Insured name:______________________

Insured date of birth:______________________

Policy number:______________________

DIAGNOSIS/TREATMENT

Product: OZURDEX®

HCPCS code: J7312 Diagnosis 1*:______________________

CPT® code: 67028 Diagnosis 2:______________________

Drug units*: ☐ 7 units

Anticipated date of treatment:____/____/________

Please note: We cannot verify benefits without a valid diagnosis code

PRESCRIBING PHYSICIAN

Site of service*: ☐ Physician's office ☐ Hospital outpatient ☐ Ambulatory surgical center

Practice/facility name*:______________________

Physician name (first and last)*:______________________ Physician specialty:______________________

Address*:______________________ City*:______________________ State*:______ Zip*:______________

Email:______________________ Phone*:______________________ Fax*:______________________

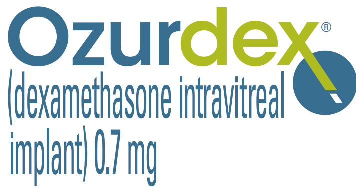
Facility Tax ID No.*:______________ Physician State License No.*:______________ Physician National Provider Identifier (NPI)*:______________

Office Contact Information

Primary office contact*:______________________

Phone*:______________________ Ext:__________ Fax:______________________ Email*:______________________

See full Prescribing Information at Ozurdex.com



HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF PATIENT INFORMATION

*Required information.

By signing below, I authorize my healthcare providers and staff, my health insurer, health plan or programs that provide me healthcare benefits, and any specialty pharmacy that dispenses my medication (collectively, my "Healthcare Providers") to disclose to Allergan®, including any affiliates, representatives, contractors, and/or agents of Allergan® (collectively "Allergan®") information about me that is necessary:

- To register me in, operate, administer, and/or provide me with access to the Allergan® online reimbursement services program, *Allergan EyeCue®*
- To investigate my health insurance coverage benefits
- To obtain prior authorization and/or assist with appeals of denied claims for coverage/reimbursement
- To register me in, operate, administer, and/or provide me with access to the OZURDEX® Savings Program
- To assist with obtaining my medication from a specialty pharmacy

I understand that the type of information that can be given under this authorization may include my name, birth date, address, telephone number, email address, information about my health condition, my treatment and prescription information, treatment dates, my medical history and general health, my healthcare plan benefits and coverage, information about my adherence to my treatment, healthcare plan records, and other relevant personal and health information (collectively, "personal information").

I further understand that if my information is incomplete, I may be notified of such by Allergan®. I also understand that signing this authorization does not guarantee that I am eligible for or will be accepted into the OZURDEX® Savings Program. I further understand that because Allergan® is not covered by federal privacy regulations, after my information is disclosed to Allergan®, it will no longer be protected under federal law and could be subject to redisclosure. This authorization will expire two (2) years after the date it is signed below unless a shorter period is required by law. I may cancel this authorization at any time by providing written notice to Allergan® at the address set forth below. My revocation will become effective on the date my written notice is received and processed by the *Allergan EyeCue®* program, and at such time I will no longer be qualified to receive copay assistance from the OZURDEX® Savings Program. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment from my healthcare provider, but I will not be able to participate in the *Allergan EyeCue®* program or OZURDEX® Savings Program.

REQUIRED

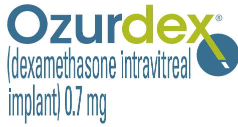
You are entitled to a copy of this authorization for your records.

Print patient name* ______________________ **Date of birth*** ____/____/________

Patient Signature/Authorized Person* ______________________ **Date*** __________

Relationship/Reason patient is unable to sign ______________________

Revocations may be sent to: *Allergan EyeCue®*, PO Box 503278, San Diego, CA 92150; fax: 1-866-676-4069



PATIENT CERTIFICATION FOR ALLERGAN® PROGRAMS

*Required information.

Consent to Enrollment in *Allergan EyeCue®*: By signing below, I am enrolling in the *Allergan EyeCue®* program and authorize Allergan®, including any affiliates, representatives, contractors, and/or agents of Allergan® (collectively "Allergan®") to provide me with services through the *Allergan EyeCue®* program.

Consent to Determine Eligibility for OZURDEX® Savings Program: By signing below, I verify that the information on this application regarding my healthcare and prescription medication insurance coverage is complete and accurate. I understand that in order to be eligible for the OZURDEX® Savings Program, I must meet the following criteria:

- Be a resident of the United States, Puerto Rico, or Guam and at least 18 years of age
- Be prescribed OZURDEX® for an approved use
- Receive treatment after January 2020
- Have commercial or private health insurance
- Have insurance coverage for OZURDEX® for an approved use
- Have no government-sponsored insurance coverage such as Medicare or Medicaid

I also understand that Allergan® may verify my eligibility for the OZURDEX® Savings Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional insurance, and/or medical information. I further understand that should I begin receiving prescription benefits from a government-sponsored insurance program, such as Medicare or Medicaid, I will no longer be eligible for the OZURDEX® Savings Program.

Consent to Communication: I understand that by signing below, I agree to receive communications from Allergan® about OZURDEX®, diseases that Allergan® products treat, other Allergan® products and services, and consumer-based market research on Allergan® products and health conditions. I understand that I can always opt out of specific communications by clicking the Unsubscribe link in any email.

☐ By checking this box, I confirm that I would like to receive automated calls and text messages regarding OZURDEX® from Allergan®. I understand that the frequency of these messages depends on user preferences/activity, and message and data rates may apply. I understand that no purchase is necessary to receive these calls or texts and that I may opt out at any time by responding "STOP" to any text message.

I understand that I do not have to enroll in *Allergan EyeCue®* or the OZURDEX® Savings Program or consent to receive communications from Allergan® in order to receive OZURDEX® as prescribed by my healthcare provider. I verify that the information on this application and other supporting documentation is complete and accurate.

You are entitled to a copy of this authorization for your records.

PATIENT SIGNATURE

REQUIRED

Print patient name* ______________________ **Date of birth*** ____/____/________

Patient Signature/Authorized Person* ______________________ **Date*** ____________

Relationship/Reason patient is unable to sign ______________________

PHYSICIAN OR DELEGATE SIGNATURE

REQUIRED

By signing below, I certify the following: (1) that I am the prescribing physician or a delegate authorized to sign on behalf of the prescribing physician; (2) that the person named on this enrollment form is my patient; (3) that to the best of my knowledge the information provided by the patient is accurate and complete; (4) that I will retain a complete patient-executed copy of this enrollment form in my files; and (5) that, upon request, I will promptly provide Allergan® with a copy of this patient-executed enrollment form.

Physician or Delegate Signature* ______________________ **Date*** ____________

Print Name (if delegate signs) ______________________

Revocations may be sent to: *Allergan EyeCue®*, PO Box 503278, San Diego, CA 92150; fax: 1-866-676-4069

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