Ozurdex® (dexamethasone intravitreal implant) 0.7 mg

PATIENT ENROLLMENT FORM

Fax: 1-866-676-4069

ARCC®

SUPPORT REQUESTED (check all that apply)

- ☑ Benefits investigation/ prior authorization
- ☑ Appeals support
- ☑ Claims assistance

Patient Financial Support Options

☑ OZURDEX PATIENT ASSISTANCE® Program (check only if patient does not have insurance coverage)

☑ Co-pay assistance

- ⊙ Patient Assistance Network Foundation
- ⊙ *CDF*®
- ⊙ *NORD*® (requires patient involvement)

REQUIRED

By completing this form, I confirm that I have the patient's written consent to release any patient-identifiable information in this form to LASH, as well as its subsidiaries and agents, for the purpose of conducting insurance verification and administrating the OZURDEX PATIENT ASSISTANCE® Program.

PATIENT

First name:_____ Middle initial:_____ Last name:_____

Date of Birth:_____/_____/_____ Gender: ☐ Male ☐ Female U.S. Resident: ☐ Yes ☐ No Social Security 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: _____

Policy number: _____

Employer: _____

Group number: _____

Secondary Insurance

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Insurance company: _____

Phone: _____

Insured name: _____

Policy number: _____

Employer: _____

Group number: _____

DIAGNOSIS/TREATMENT

Product: OZURDEX®

Diagnosis 1:_____ *CPT*® code 1:_____

Diagnosis 2:_____ *CPT*® code 2:_____

Diagnosis 3:_____

Diagnosis 4:_____

Please note: We cannot verify benefits without a diagnosis code

Eye(s) being treated (check all that apply): ☐ Rt ☐ Lt

Drug units: ☐ 7 units ☐ 14 units

Has patient started treatment? ☐ Yes ☐ No

Anticipated date of treatment:____/____/_____

PRESCRIBING PHYSICIAN

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

Practice/facility name:_____

Physician name:_____ Physician specialty:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Phone:_____ Fax:_____

Physician's Tax ID No.:_____ Physician National Provider Identifier (NPI):_____

PTAN No.:_____ Group NPI No.:_____

State License No. (only for OZURDEX PATIENT ASSISTANCE® Program):_____

Office Contact Information

Primary office contact: Lucy Madrigal

Phone: 951-566-9513 Ext:_____ Fax: 951-672-6667 Email: lmadrigal@ivretina.com

PATIENT NAME

First name:_____ Middle initial:_____ Last name:_____

Patient's preferred language:

☐ English ☐ Spanish ☐ Other: _____

Alternate contact:_____ Phone No: _____

Permission to reach alternate contact ☐ Yes ☐ No

FINANCIAL INFORMATION

Financial Information

(Must be completed for patient assistance requests)

Total household income for the previous calendar year: $_____

Number of individuals in household:_____

PATIENT CERTIFICATION

By signing below, I verify that the information provided on this application is complete and accurate to the best of my knowledge.

I agree to be fully compliant in taking the drug for which financial assistance is being provided, in accordance with my doctor's direction.

I also agree that Allergan, Inc., may verify my eligibility for the OZURDEX PATIENT ASSISTANCE® Program, and I understand that such verification may include contacting me or my healthcare provider for additional information and/or reviewing additional financial, insurance, and/or medical information.

Under the OZURDEX PATIENT ASSISTANCE® Program, Allergan, Inc., agrees to ship product to the healthcare provider for OZURDEX® (dexamethasone intravitreal implant) 0.7 mg for patient use, and Allergan, Inc., may contact me or my healthcare provider to confirm receipt of the medication or to provide other information related to the program.

I also understand that Allergan, Inc., reserves the right to change or terminate the OZURDEX PATIENT ASSISTANCE® Program at any time without further notice.

Sign and date here.

Patient or guardian signature:_____ Date:_____/_____/_____

PHYSICIAN PATIENT SIGNATURE CERTIFICATION

By signing below, I certify the following: (1) that the person named on this enrollment form is my patient; (2) I have obtained his/her written Patient Certification provided on this form; (3) that to the best of my knowledge the financial information provided by the patient is accurate and complete; (4) that I will retain a complete patient-executed copy of this enrollment form; and (5) that, upon request from Allergan, Inc., I will promptly provide a copy of this patient-executed OZURDEX PATIENT ASSISTANCE® Program enrollment form.

I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed treatment. I understand that I cannot bill a patient for units provided through the OZURDEX PATIENT ASSISTANCE® Program, and if I received any remuneration (ie, patient co-pay or coinsurance) for a PAP unit received post injection (retroactive PAP), then I will fully refund the patient's expenses. Information provided will be used in accordance with OZURDEX PATIENT ASSISTANCE® Program eligibility requirements (see OZURDEX PATIENT ASSISTANCE® Program criteria).

I understand that a copy of the patient's insurance denial/appeal records could be requested for the purposes of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, I understand that the OZURDEX PATIENT ASSISTANCE® Program will pursue all appropriate legal remedies, including seeking damages in litigation, in the event the OZURDEX PATIENT ASSISTANCE® Program determines this certification is false or the insurance attestation is false or inaccurate.

NOTE: Physician signature required only for OZURDEX PATIENT ASSISTANCE® Program, applicable only when patient has no insurance.

Sign and date here.

Physician signature:_____ Date:_____/_____/_____

Please complete this application and submit by fax to 1-866-676-4069 or retain a completed, patient-signed form on file at your office if the application was submitted at www.AllerganRCC.com.

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Phone 1-866-OZURDEX (698-7339) Option 4 between 9:00 AM and 8:00 PM ET.

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