OXERVATE® PATIENT ENROLLMENT FORM

DC2C ACCREDO

INSTRUCTIONS:

- **Complete all pages of this form for each new prescription. Please print.**
- **Please fax completed form to Dompé CONNECT to Care at 1-855-263-1775, phone 1-877-422-4412.**
- **Please provide copies of front and back of all insurance cards.**

PATIENT INFORMATION

Name (Last, First, Middle Initial): Date of Birth:

Address: City: State: ZIP:

Preferred Phone: Alternative Phone: Best Time to Call: ☐ Day ☐ Evening

Patient Email: Preferred Language:

SSN (last 4 digits): Gender: ☐ Male ☐ Female

Caregiver Contact Name: Caregiver Contact Phone Number:

Okay to leave message with alternate caregiver/contact? ☐ Yes ☐ No

TREATMENT INFORMATION/PRESCRIPTION (physician to fill out)

Treated Eye (select one): ☐ Left ☐ Right ☐ Both eyes

Stage- Left Eye (select one): ☐ Mild (Stage 1) ☐ Moderate (Stage 2) ☐ Severe (Stage 3)

Stage- Right Eye (select one): ☐ Mild (Stage 1) ☐ Moderate (Stage 2) ☐ Severe (Stage 3)

Check all ICD-10 codes that apply to the treated eye(s):

ICD-10 Codes Check all that apply	Central corneal ulcer	Unspecified corneal ulcer	Neurotrophic Keratoconjunctivitis	Anesthesia and hypoesthesia of cornea	Other
Right eye	☐ H16.011	☐ H16.001	☐ H16.231	☐ H18.811	☐
Left eye	☐ H16.012	☐ H16.002	☐ H16.232	☐ H18.812	☐

Product: OXERVATE® (cenegermin-bkbj) ophthalmic solution 0.002% (20 mcg/mL), x8 units* **NDC Code:** 71981-020-07

Description: The OXERVATE prescription is for 8 weeks, with weekly quantities being dispensed in a single package. Each weekly package contains 7 multi-dose daily vials and a delivery system kit (NDC- 71981-001-01).

Unilateral: Instill one drop of OXERVATE in the affected eye, 6 times a day at 2-hour intervals for 8 weeks.
Bilateral: Instill one drop of OXERVATE in each eye, 6 times a day at 2-hour intervals for 8 weeks.*

*If both eyes are affected then this prescription is valid for two 8-week treatments. Two vials will be used per day (1 vial for each affected eye).

Contact lenses should be removed before applying OXERVATE and may be reinserted 15 minutes after administration. If a dose is missed, treatment should be continued as normal, at the next scheduled administration.

If more than one topical ophthalmic product is being used, administer the eye drops at least 15 minutes apart to avoid diluting products. Administer OXERVATE 15 minutes prior to using any eye ointment, gel, or other viscous eye drops.

For more information, please see the full Prescribing Information at www.oxervate.com/prescribing-information.

Prescriber Signature: (dispense as written) **No refills**

Prescriber Signature: (substitution allowed) (no stamps) Date:

This document and signature authorizes the transmission of all necessary information for the prescription to the dispensing pharmacy. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. For New York prescribers: In addition to this completed form, provide New York-specific prescription blanks. ☐ Check here if this is an e-prescription.

PRESCRIBING PHYSICIAN INFORMATION

Prescriber (First and Last Name and Title): If APRN, PA or R.Ph. Supervising Physician:

NPI Number: Site/Facility Name:

Address: City: State: ZIP:

State License #: Tax ID #: Medicaid/Medicare Provider #:

Office Phone: Office Fax:

Preferred method of communication: Office Contact Name:

Office/Account Email:

OXERVATE PATIENT ENROLLMENT FORM, continued

PATIENT INSURANCE INFORMATION

Primary Insurance Plan (check one): ☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Other

Policy Holder's Name: Policy Holder's Date of Birth:

Insurance Plan Name: Phone Number:

Employer: Policy Number: Group Number:

Secondary Insurance Plan (check one): ☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Other

Policy Holder's Name: Policy Holder's Date of Birth:

Insurance Plan Name: Phone Number:

Employer: Policy Number: Group Number:

Prescription Drug Benefit Coverage/Pharmacy Benefit Manager:

VOLUNTARY PATIENT AUTHORIZATION TO SHARE INFORMATION WITH DOMPÉ

By signing this patient authorization ("Authorization"), I hereby authorize my health plans, health care providers, healthcare clearinghouses, and their business associates ("Covered Entities," as such term is defined under the Health Insurance Portability and Accountability Act ("HIPAA")) to use and disclose my Protected Health Information ("PHI" as such term is defined HIPAA) to Dompé U.S. Inc., its parent company, and its affiliated entities, employees, representatives, agents, and contractors including, but not limited to the administrator of Dompé CONNECT to Care (collectively, "Dompé") (or, if applicable, to use and disclose the PHI of the patient for whom I am the parent, legal guardian, or caretaker).

PHI includes information related to my medical condition(s), treatment, medications, care management, and health insurance, as well as contact and other information provided on this form and any prescription form. This may include information about sexually transmitted infections, HIV status, substance dependencies or treatments if included in your file and relevant to the purposes described in this form.

By and through this Authorization, I authorize Dompé to use my PHI for the following purposes:

1. To establish eligibility for Dompé CONNECT to Care benefits.
2. To communicate with Covered Entities and me about my medical care.
3. To facilitate the provision of Dompé products, supplies, or services through a third party, including, but not limited to specialty pharmacies.
4. To register me in any Dompé product registration program recommended for my treatment.
5. To enroll me in patient support programs offered by Dompé or other entities for which I may be eligible based on my PHI, including but not limited to CONNECT to Care, and or certain nursing support services, if available.
6. To send me communications from Dompé regarding my experience with Dompé products or services, and or Dompé CONNECT to Care. Such communications may include survey and other market or clinical research invitations, but do not include direct marketing activities.

I understand and agree that:

7. The Covered Entities may receive direct or indirect remuneration from Dompé in exchange for sharing my PHI with Dompé pursuant to this Authorization.
8. Dompé contractors who receive my disclosed PHI from Dompé for the purposes listed above may also receive remuneration from Dompé in exchange for their communications with me about Dompé CONNECT to Care services, and or their provision of to me of therapy support services subsidized by Dompé.
9. Dompé may use and share my PHI to send me or cause third parties to send me information or materials related to OXERVATE® (or any other Dompé products or services which may be of interest to me based on my PHI), to contact me occasionally to get my feedback (for market research purposes) about OXERVATE or OXERVATE Programs, and as otherwise required or permitted by law.
10. Any PHI disclosed to Dompé by the Covered Entities pursuant to this authorization will no longer be protected by the Covered Entities' HIPAA obligations, but will be kept confidential by Dompé and protected under privacy laws applicable to Dompé.
11. In the event of a business transaction such as the sale or reorganization of all or part of Dompé's business, my PHI may be transferred to a purchaser or successor company to permit the above uses to be continued after the transaction.

I also understand and acknowledge that:

12. I may refuse to sign this Authorization, and that my treatment, payment, enrollment, or eligibility for benefits is not conditioned upon my agreement to grant and sign this Authorization.
13. I am entitled to a copy of this Authorization. When signed, a copy of this Authorization will be emailed to the email address provided. In the event I do not receive a copy, I may request one by emailing Dompeconnect2Care@AssistRx.com or mailing a request to: P.O. Box 7613 Overland Park, Kansas 66207.
14. I may revoke this Authorization at any time in writing by mailing a letter to Dompé CONNECT to Care at P.O. Box 7613 Overland Park, Kansas 66207, or by email to: Dompeconnect2Care@AssistRx.com. Processing of my request to revoke this Authorization may take up to 30 days from the date of receipt to the physical and or email address indicated above, whichever is received first.
15. A request to revoke this Authorization will apply except to the extent that a Covered Entity has already acted and relied on it, and therefore such revocation will not protect any PHI used or disclosed to Dompé by the Covered Entities before the date of receipt and processing of my request to revoke.
16. Unless earlier revoked, this Authorization will be valid for ten (10) years from the date of my signature below or as otherwise permitted or limited by law.

A photocopy or digital copy of this Authorization will have the same force and effect as the original.

☐ I do not want to receive any type of communications from Dompé Connect to Care.

Patient/Guardian Signature: Date:

Patient/Guardian Print Name:

PHYSICIAN ENROLLMENT CERTIFICATION

I authorize Dompé U.S., Inc., its affiliates, agents, and contractors (collectively, "Dompé Connect to Care") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. I verify the information I have provided in the enrollment form is complete and accurate to the best of my knowledge. I have obtained the patient's authorization, as indicated below, to disclose his or her health information related to the treatment of OXERVATE to Dompé U.S. and its authorized "Dompé Connect to Care" agents to use and disclose as necessary in the provision of health services or to offer patient care and support services and/or reimbursement support services.

Prescriber Signature: Date: