DC2C

DOMPÉ PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION

INSTRUCTIONS:

- **Please fax completed form to Dompé CONNECT to Care at 1-855-263-1775, phone 1-877-422-4412.**

*Denotes required field.

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US-OXE-2500043.1 07/25

PATIENT INFORMATION

Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

*Patient 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:

Caregiver Contact Name: Caregiver Contact Phone Number: Ok to leave message with caregiver? Yes ☐ No ☐

Annual Household Income: Total Number of People in Household:

Residency: (I am a US resident for at least 6 months or am a US citizen) Yes ☐ No ☐

Dompé or its representatives will verify patient income through collection of appropriate financial documents.

ELIGIBILITY AND TREATMENT INFORMATION

*Diagnosis:

Insurance: (*Attach copy of patient's insurance cards, front and back, if applicable.*)

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

Patient is underinsured (no coverage for OXERVATE® (cenegermin-bkbj) ophthalmic solution 0.002% (20 mcg/mL)): Yes ☐ No ☐ *(Attach copy of insurance denial/ appeal.)*

PRESCRIBING PHYSICIAN INFORMATION

*Prescriber (Title, First Name, Last):

*Address:

*City: *State: *ZIP:

*Office Number: *Office fax: *Office/Account Email:

Preferred Method of Communication: Office Contact Name:

VOLUNTARY PATIENT AUTHORIZATION TO SHARE WITH DOMPÉ

HEALTH INFORMATION CONSENT

As part of our Dompé CONNECT to Care ("DC2C") (the "Services") we collect certain information about your health conditions and diagnoses from you and, with your authorization, your healthcare providers to help us safely provide Services to you. If you choose not to provide this information, we cannot provide our Services. For more information on our data processing practices and rights you may have, please see our Privacy Policy available at https://www.dompe.com/us/privacy-policy/. If you (or your healthcare provider, with your authorization) provide the information and you later change your mind, you may withdraw your consent for future processing or request deletion of your health information at any time by contacting privacy@dompe.com.
By signing below, I consent to Dompé U.S. Inc., its affiliates and service providers (collectively "Dompé") collecting and using my health information to provide the Services.

CONTINUED ON NEXT PAGE. PATIENT SIGNATURE REQUIRED.

DOMPÉ PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION, continued

*Denotes required field.

VOLUNTARY PATIENT AUTHORIZATION TO SHARE WITH DOMPÉ, continued

VOLUNTARY PATIENT AUTHORIZATION TO SHARE INFORMATION WITH DOMPÉ

By signing this patient authorization ("Authorization"), I (or the legal guardian or caretaker of such patient on their behalf) hereby authorize my health plans, healthcare 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 health information, which may, under some circumstances be considered Protected Health Information ("PHI" as such term is defined under HIPAA) to Dompé (as defined above) including, but not limited to the administrator of the Services (as defined above).

Health information that may be transferred to Dompé 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 my file and relevant to the purposes described in this form.

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

1. To establish eligibility for the Services. 2. To communicate with Covered Entities and me about my medical care and coverage. 3. To facilitate, assess, support or improve the provision of Dompé products, supplies, or services, including the Services, provided by Dompé or through a third party, including, but not limited to our access hub(s) or specialty pharmacy(ies). 4. To enroll me in patient or product support programs offered by Dompé or other entities for which I may be eligible based on my health information, including but not limited to any OXERVATE® patient support program, and or certain nursing support services, if available. 5. To use and share my information to send me or cause third parties to send me communications and or information regarding my experience with access to and use of OXERVATE and or other Dompé products or services. Such communications may include survey and other market or clinical research invitations, as well as marketing communications. 6. As otherwise required or permitted by law.

I understand and agree that:

1. Dompé contractors or vendors who receive my health information from Dompé for the purposes listed above may also receive direct or indirect remuneration from Dompé in exchange for their communications with me about Dompé patient or product support programs or support services subsidized by Dompé. 2. Any health information 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 subject to its Privacy Policy (located at: dompe.com/us/privacy-policy), and such privacy laws applicable to Dompé. 3. In the event of a business transaction such as the sale or reorganization of all or part of Dompé's business, my health information may be transferred to a purchaser or successor company to permit the above uses to be continued after the business transaction.

I also understand and acknowledge that:

1. I may refuse to sign this Authorization and that access to Dompé's products and or eligibility for insurance benefits are not conditioned upon my agreement to grant and sign this Authorization. 2. Upon signature, I may request a copy of the signed Authorization. When filled out electronically, I may download a copy of this Authorization or request that this Authorization be emailed to the email address provided. 3. I may revoke this Authorization at any time in writing by mailing a letter to 1680 Century Center Pkwy, Suite 4, Memphis TN 38134, 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. 4. 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 health information used or disclosed to Dompé by the Covered Entities before the date of receipt and processing of my request to revoke the Authorization. 5. 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. 6. A photocopy or digital copy of this Authorization will have the same force and effect as the original.

For more information, reply HELP to any Message or contact Dompé at: DompeConnect2Care@AssistRx.com.

☐ I would like to opt out of commercial communications from Dompé CONNECT to Care.

☐ **Dompé Telephone Consumer Protection Act (TCPA) Authorization**
I authorize Dompé, its affiliates and service providers including, but not limited to Dompé's specialty pharmacy(ies), its access hub(s) to send me recurring automated text messages and/or call me using live, artificial or pre-recorded voice messages which may be sent using an automatic telephone dialing system or other similar technology now existing or later developed ("Messages") to provide updates, alerts, educational materials, marketing communications, and or information (e.g., materials or communications related to Dompé and or Dompé products or services, etc.) or to get my feedback (for market research purposes) about OXERVATE or OXERVATE programs, and as otherwise required by law. I consent to the receipt of Messages to the phone number(s) I provided in this form, even if the phone number(s) are registered on any state or federal Do Not Call list. Standard message and data rates may apply. Message frequency varies. I understand that this TCPA consent is valid until revoked and that it is not required to receive goods or services. To unsubscribe from the Messaging program, I may reply STOP to any text message or may email DompeConnect2Care@AssistRx.com. Following such a request to unsubscribe, I consent to receive one additional Message confirming that the request has been processed.

Patient Signature: _____ Date: _____