Prescription Information and Enrollment Form

Complete and fax this form to 866-272-8839
For assistance, call 866-272-8838, Monday-Friday, 9:00 AM-5:00 PM, EST

BAUSCH + LOMB

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____

DOB (MM/DD/YYYY) _____ SSN _____ SEX ☐ M ☐ F

ADDRESS _____

CITY _____ STATE ____ ZIP CODE _____ E-MAIL _____

CELL _____ HOME PHONE _____ WORK PHONE _____

PREFERRED NUMBER TO CALL ☐ Cell ☐ Home ☐ Work BEST TIME TO CONTACT ☐ Morning ☐ Afternoon ☐ Evening

2. INSURANCE INFORMATION (REQUIRED)

☐ ENLARGED COPY OF PRESCRIPTION CARD(S) ATTACHED ☐ NO INSURANCE

PRESCRIPTION INSURER _____ PHONE _____

BIN # _____ MEMBER ID # _____

PRIMARY INSURANCE _____

CARDHOLDER _____ RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY # _____ GROUP # _____ MEMBER ID # _____

3. PATIENT AUTHORIZATION

Patient should read this Patient Authorization and sign below.

PATIENT AUTHORIZATION

I authorize my healthcare providers and health plans to disclose my protected health information ("PHI") to Bausch + Lomb and its agents and contractors ("Bausch + Lomb") to: (1) establish my eligibility for benefits through the FOCUS ON ACCESS™ (FOA) program; (2) communicate with my health care providers and me about my medical care; and (3) provide support services including facilitating the provision of product to me. I understand that once my PHI has been disclosed to Bausch + Lomb federal privacy laws may no longer restrict its further disclosure. Bausch + Lomb agrees to use and disclose this information only for the above purposes and as permitted by law. I further understand I may refuse to sign this authorization and that my health care providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I may cancel this authorization by notifying Bausch + Lomb in writing and submitting the cancellation by fax to: 1-866-272-8839. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

Signature of Patient/Personal Representative Date

Print Name of Patient Personal Representative Relationship to Patient (If Applicable)

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) Alan Wagner, MD Kapiil Kapoor, MD

SPECIALTY Retina OFFICE CONTACT Alice Murray

PRACTICE NAME Wagner Macula and Retina Center

ADDRESS 6160 Kempsville Cir, Suite 250

CITY Norfolk STATE VA ZIP CODE 23502

E-MAIL amurray@wagnerretina.com PHONE 757-481-4400 FAX 757-481-1285

MEDICAID/MEDICARE PROVIDER # _____ TAX ID # 541406743

STATE LICENSE # 0101039260 0101253797 UPIN/NPI # 1295719631 1093906281

5. PRESCRIPTION CLINICAL INFORMATION

PRODUCT(S) REQUEST–CHECK SELECTION

☐ **Macugen® (pegaptanib sodium injection)** ☐ **Retisert® (fluocinolone acetonide intravitreal implant) 0.59mg**
☐ **Visudyne® (verteporfin for injection)**

☐ Left Eye ☐ Right Eye ☐ Bilateral:

Diagnosis/ICD-10 Code: _____

6. PHYSICIAN CERTIFICATION

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE (NO STAMPS ALLOWED): I attest that the information provided is current, and accurate to the best of my knowledge. I certify that product is medically necessary for this patient and I will be supervising the patient's treatments. I have obtained from my patient all required authorizations for the release to Bausch + Lomb and its agents and representatives of my patient's identification and insurance information. I understand that any information provided is for the sole use of Bausch + Lomb and its agents and representatives to verify my patient's insurance coverage and to assess, if applicable, patient's eligibility for participation in the patient assistance program ("PAP") and to otherwise administer the FOA program. I understand that application to the PAP does not guarantee that assistance will be obtained. I understand that if my patient's insurance status changes, he/she may no longer be eligible for the PAP, and I agree to immediately notify FOA if I become aware of such a change in status. I certify that I will not bill for or accept payment from patients (or any third party), in whole or in part, for product obtained through the PAP. I agree that if a retroactive insurer claim decision or policy change results in reimbursement to me for product supplied through the PAP, I will immediately notify a FOA representative, and I understand that in such event Bausch + Lomb will bill me for the reimbursement product, and I agree to be responsible for payment of the bill. I understand that I am under no obligation to prescribe product and that I have not received nor will I receive any benefit from Bausch + Lomb or its agents or representatives for prescribing product.

SIGNATURE _____ Date

7. SHIPPING INFORMATION (Please provide shipping information if product is being shipped to location other than prescriber's office)

PRESCRIBER NAME _____

ADDRESS _____

CITY _____ STATE ____ ZIP CODE _____ PHONE _____