P: 1-844-445-8843, Option 3
F: 1-844-501-7161

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PATIENT ENROLLMENT FORM

*Indicates Required Field

PATIENT INFORMATION

*Patient First Name: ____________ Middle Initial: ______ *Last Name: ____________

Complete the following patient information OR attach EMR face/demographic sheet to this enrollment. YOU MUST COMPLETE THE PATIENT FIRST AND LAST NAME ABOVE.

☐ **EMR Face/Demographic Sheet Attached.**

*Date of Birth: ____/____/____ *Gender: ☐ Male ☐ Female Patient EMR #: ____________ *Social Security #: ____ – ____ – ____

Primary Language: ____________ *Primary Phone: (____) ____________ Secondary Phone: (____) ____________

*Address: ____________ *City: ____________ *State: ____ *Zip: ____________

AccessPlus may contact this patient to obtain information relating to this enrollment: ☐ Yes ☐ No

INSURANCE

REQUIRED: Please attach copy of patient's insurance card(s) (front and back) and/or EMR face/demographic sheet to this enrollment.

☐ **Copy of Insurance Card(s) Attached.** ☐ **EMR Face/Demographic Sheet Attached.**

Primary Insurance: ____________ ☐ Medicare ☐ Medicare Advantage ☐ Commercial/Private ☐ Medicaid ☐ Other: ____________

Secondary Insurance: ____________ ☐ Medicare ☐ Medicare Advantage ☐ Commercial/Private ☐ Medicaid ☐ Other: ____________

PRESCRIBER & OFFICE INFORMATION

***Prescribing Physician First Name:** Alan Kapil ***Last Name:** Wagner Kapoor ***NPI #:** 1295719631 1093906281

***Place of Service Zip Code:** ____________ ***Place of Service:** ☐ Physician Office ☐ Hospital Outpatient ☐ Ambulatory Surgery Center

*Required for Hospital Outpatient /ASC Place of Service: HOPD or ASC Site Name: ____________

HOPD or ASC Tax ID#: ____________

☐ **Specialty Pharmacy Requested for Dispensing** **Known Drug Allergies** (required for SP Prescription): ____________

(AccessPlus will fax an ILUVIEN Prescripton Referral form to you for the prescriber's signature so that we may investigate SP availability based on the patient's benefit structure.)

***Primary Office Contact for this Patient Enrollment:**

*Name: Alice Murray *Phone: (757) 481-4400 ext 318

Email: amurray@wagnerretina.com ***Fax benefit investigation results to:** (757) 481-1285

PATIENT DIAGNOSIS

***DIAGNOSIS**

	Right Eye	Left Eye	Bilateral
Diabetes mellitus due to underlying condition with…			
Mild nonproliferative diabetic retinopathy with macular edema	☐ E08.3211	☐ E08.3212	☐ E08.3213
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E08.3311	☐ E08.3312	☐ E08.3313
Severe nonproliferative diabetic retinopathy with macular edema	☐ E08.3411	☐ E08.3412	☐ E08.3413
Proliferative diabetic retinopathy with macular edema	☐ E08.3511	☐ E08.3512	☐ E08.3513
Drug or chemical induced diabetes mellitus with…			
Mild nonproliferative diabetic retinopathy with macular edema	☐ E09.3211	☐ E09.3212	☐ E09.3213
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E09.3311	☐ E09.3312	☐ E09.3313
Severe nonproliferative diabetic retinopathy with macular edema	☐ E09.3411	☐ E09.3412	☐ E09.3413
Proliferative diabetic retinopathy with macular edema	☐ E09.3511	☐ E09.3512	☐ E09.3513
Type 1 diabetes mellitus with…			
Mild nonproliferative diabetic retinopathy with macular edema	☐ E10.3211	☐ E10.3212	☐ E10.3213
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E10.3311	☐ E10.3312	☐ E10.3313
Severe nonproliferative diabetic retinopathy with macular edema	☐ E10.3411	☐ E10.3412	☐ E10.3413
Proliferative diabetic retinopathy with macular edema	☐ E10.3511	☐ E10.3512	☐ E10.3513
Type 2 diabetes mellitus with…			
Mild nonproliferative diabetic retinopathy with macular edema	☐ E11.3211	☐ E11.3212	☐ E11.3213
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E11.3311	☐ E11.3312	☐ E11.3313
Severe nonproliferative diabetic retinopathy with macular edema	☐ E11.3411	☐ E11.3412	☐ E11.3413
Proliferative diabetic retinopathy with macular edema	☐ E11.3511	☐ E11.3512	☐ E11.3513
Other specified diabetes mellitus with…			
Mild nonproliferative diabetic retinopathy with macular edema	☐ E13.3211	☐ E13.3212	☐ E13.3213
Moderate nonproliferative diabetic retinopathy with macular edema	☐ E13.3311	☐ E13.3312	☐ E13.3313
Severe nonproliferative diabetic retinopathy with macular edema	☐ E13.3411	☐ E13.3412	☐ E13.3413
Proliferative diabetic retinopathy with macular edema	☐ E13.3511	☐ E13.3512	☐ E13.3513

☐ **Other Diagnosis Code(s):** ____________

*PRIOR CORTICOSTEROID HISTORY

REQUIRED: Please complete this section with the patient's prior corticosteroid treatment history.

Prior corticosteroid treatment required per the FDA labeled indication for ILUVIEN.

Medication Prescribed: ____________

Date Prescribed: ____________

☐ Patient did not have a clinically significant rise in intraocular pressure.

TREATMENT INFORMATION

Anticipated Date of Treatment with ILUVIEN: ____________

Patient must sign and date the Patient Authorization and Notice of Release of Information on page 3 for this Patient Enrollment form to be processed.

Please fax completed Patient Enrollment to AccessPlus at 1-844-501-7161.

*Indicates required field. Alimera Sciences reserves the right to change or cancel the AccessPlus Program at any time.

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FINANCIAL ASSISTANCE

FINANCIAL ASSISTANCE

Please complete this section if patient would like AccessPlus to investigate financial assistance options for ILUVIEN.

Annual Household Income: $ ______________________ Number in Household (including patient): __________

ILUVIEN COPAY PROGRAM

ILUVIEN CoPay Program[1]: Patients with commercial or private insurance that covers ILUVIEN for the approved indication are eligible for the program. Patient must be resident of the United States. The program does not have an income eligibility requirement and there is not a maximum assistance level. Patient is responsible for the first $25 of the co-pay for ILUVIEN. **Household income and number in household is required information for program approval.**

Proof of income may be requested for auditing purposes. Program does not include assistance for patient cost share for injection procedure or other costs associated with the administration of ILUVIEN.

FOUNDATION ASSISTANCE

Foundation Assistance: Foundations are independent, non-profit organizations dedicated to providing underinsured patients with financial assistance through disease-specific funds. For ILUVIEN, financial assistance may be available through a Macular Disease Fund established by a foundation.

☐ We would like assistance with the process of initiating an application with a foundation for this patient.

Preferred Foundation: ____

If assistance with the foundation application process is selected, patient is required to read, sign and date the following:

FOUNDATION APPLICANT INSTRUCTIONS AND AUTHORIZATION:

Please read through this information carefully. If you have any questions, please talk to your health care provider's office.

I hereby attest and certify that the information provided here is complete and accurate. I understand and agree that the foundation(s), and their authorized third party agents, may use my demographic information, including but not limited to, my social security number, date of birth, name and address to obtain information about me from third parties to evaluate my application for financial assistance from a foundation. I authorize the foundation(s) and their authorized third party agents to obtain consumer records about me, including my credit information and other information derived from public and other sources in order to estimate my income and determine my eligibility for financial assistance from the foundation. AccessPlus has been advised that the soft credit inquiry used in the application process does not impact the patient's credit score. I also authorize the foundation(s) and their authorized third party agents to obtain information about me from sources of information other than consumer reporting agencies in order to assess my eligibility for financial assistance from a foundation.

I understand that the foundation(s) and their authorized third party agents reserve the right to ask for additional documents and information at any time. I also understand that the financial information I report may be subject to an audit, as deemed necessary by the foundation(s) providing financial assistance to me.

I further understand that any false or incomplete information I provide to the foundation(s) could unduly harm the foundation, its reputation, and its tax-exempt status and, therefore, may also constitute fraud for which I may be legally liable. I understand that any financial assistance provided to me by a foundation may be recouped, if the foundation becomes aware of any inaccurate information or fraudulent activity relating to the application or the assistance provided.

I understand that assistance is not guaranteed or promised. Any assistance the foundation may provide is limited to the terms and conditions established by the foundation. The foundation reserves the right at any time, and for any reason, without notice, to (1) modify the application form, (2) modify the eligibility criteria, or (3) modify or discontinue any assistance.

This authorization is effective for 1 year from the date set forth below with my signature.

APPLICANT AUTHORIZATION

☐ **By signing below I agree to the Applicant Authorization and Instructions set forth above.**

You must sign and date here

______________________ ______________________ __________
Signature of Patient or Legally Authorized Person (Power of Attorney) **Relationship to Patient** **Date Signed**

You must fill this out

______________________ ________ ______________________
Patient's First Name **Middle Initial** **Last Name**

If signing for patient, you must fill this out

______________________ (______) ______________________
Name of Legally Authorized Person (Power of Attorney) **Contact Phone**

[1]The ILUVIEN CoPay Program is valid ONLY for patients with commercial (private or non-governmental) insurance. It is not valid for patients who are Government beneficiaries or whose prescription drugs are covered, in whole or in part, under Medicaid, Medicare, a Medicare Part D or Medicare Advantage plan, TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan, or any other state or federal healthcare program. Patients who become Government beneficiaries during their enrollment period will no longer be eligible for the program as of the date they become a Government beneficiary.

Patient must sign and date the Patient Authorization and Notice of Release of Information on page 3 for this Patient Enrollment form to be processed.

Please fax completed Patient Enrollment to AccessPlus at 1-844-501-7161.
***Indicates required field. Alimera Sciences reserves the right to change or cancel the AccessPlus Program at any time.**

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION

AccessPlus Program

AccessPlus is a free program offered to you from Alimera Sciences. AccessPlus works on behalf of you and your health care provider to research and coordinate your health insurance coverage for ILUVIEN, assess your out-of-pocket costs associated with ILUVIEN based on your health insurance benefit plan, refer you to programs or foundations that may be able to provide assistance to you for the costs of ILUVIEN and to assist with determining your eligibility for the AccessPlus CoPay Program which helps you pay for ILUVIEN. We assist people who have a health care plan as well as those who do not.

If you do not have a health care plan, or your plan will not pay for ILUVIEN, we may be able to help. If you meet certain financial and medical criteria, we can supply free medication. This is done through the AccessPlus Patient Assistance Program.

For us to help, we need to look at, use and disclose your protected health information (PHI). Your health care provider and health care plan can disclose your PHI to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PHI to us, and you are authorizing us to disclose your PHI as necessary to perform services for you. Once you sign this form and it is sent back to us by you or your health care provider on your behalf, we can start to provide these services.

You can choose not to agree to this authorization; however, it is important for you to understand that we cannot provide our services without your authorization. This means you might need to pay for ILUVIEN on your own.

Patient Authorization to Disclose/Use Health Information

Please read through this information carefully. If you have any questions, talk to your health care provider's office or call us at 1-844-445-8843, Option 3.

I hereby authorize my health care providers, health care plans, insurers or programs that provide me healthcare benefits and any specialty pharmacies to disclose to Alimera Sciences and its representatives (including RxCrossroads) and contractors (together "Alimera") my protected health information ("PHI"). This includes all of my health records relating to my treatment, information about my health care plan benefits and any information having a bearing on my health or my treatment with ILUVIEN.

I understand that my specialty pharmacy provider may receive remuneration from Alimera Sciences in exchange for disclosing to AccessPlus my health care plan benefits, including PHI, for treatment with ILUVIEN.

My PHI may be used only in these ways: operating and administering of the AccessPlus program, reviewing and providing assistance in connection with my health care plan coverage for ILUVIEN, applying to the AccessPlus Patient Assistance Program, determining eligibility for alternative forms of coverage and sources of funding, coordination of prescription fulfillment through a pharmacy, tracking my use of ILUVIEN, and for the administrative purposes of Alimera Sciences representatives.

This authorization and notice of release is effective for 3 years from the date set forth below with my signature. Once I sign this form, I know that my PHI might not be covered by any federal law that restricts the use and disclosure of my PHI. There is no guarantee that my PHI might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release. However, Alimera agrees to protect my PHI by using and disclosing it only for the purposes authorized herein or as required by law.

I know I can choose not to sign this form. I may withdraw authorization at any time and for any reason. This will not affect my eligibility to obtain medical treatment with ILUVIEN and will have no impact on my treatment by my health care provider. To withdraw authorization, I must send a written notice to Alimera Sciences. It can be sent by fax to **1-844-501-7161** or by mail to **Alimera Sciences, AccessPlus, c/o RxCrossroads, PO Box 5873, Louisville, KY 40205**. Alimera shall provide timely notification of my withdrawal (revocation) to my health care providers, health care plans, insurers or programs that provide me healthcare benefits and any specialty pharmacies. Once they receive and process the notice of withdrawal (revocation) of this authorization, they may no longer disclose my PHI to Alimera. However, cancelling this authorization will not affect Alimera's ability to use and disclose my PHI that it has already received (unless the laws of my state prevent Alimera from continuing to use and disclose such PHI). This withdrawal goes into effect once it is received by Alimera Sciences. If I do not sign this form or if I withdraw my authorization, Alimera Sciences will not be able to help me with the AccessPlus program.

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release. I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PHI as discussed above. Please complete all of the information below, and be sure to sign and date this form so that there is no delay in starting the AccessPlus program services.

PATIENT AUTHORIZATION

☐ **I have read and agree to the attached Patient Authorization and Notice of Release.**

You must sign and date here

Signature of Patient or Legally Authorized Person ____________ **Relationship to Patient** ____________ **Date Signed** ____________

You must fill this out

Patient's First Name ____________ **Middle Initial** ____________ **Last Name** ____________

If signing for patient, you must fill this out

Name of Legally Authorized Person ____________ **Contact Phone of Legally Authorized Person** (______) ____________

Patient must sign and date the Patient Authorization and Notice of Release of Information (above) for this Patient Enrollment form to be processed.

Please fax completed Patient Enrollment to AccessPlus at 1-844-501-7161.

***Indicates required field. Alimera Sciences reserves the right to change or cancel the AccessPlus Program at any time.**