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

accessplus
Reimbursement and Patient Assistance

ILUVIEN®
(fluocinolone acetonide intravitreal implant) 0.19mg

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 #: _____

Primary Language: _____ Primary Phone: (____) _____ Secondary Phone: (____) _____

*Address: _____ *City: _____ *State: ____ *Zip: _____

*Patient Email: _____ 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 Plan Name: _____ *ID#: _____

*Group#: _____ *Plan Phone: ( ) _____

*Secondary Insurance Plan Name: _____ *ID#: _____

*Group#: _____ *Plan Phone: ( ) _____

PRESCRIBER & OFFICE INFORMATION

***Prescribing Physician First Name:** _____ ***Last Name:** _____ ***NPI #:** _____

***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: _____ *Phone: (____) _____

*Email: _____ ***Fax benefit investigation results to:** (____) _____

Corticosteroid Prior History

***IMPORTANT:** THIS SECTION MUST BE FILLED OUT

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

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

*Prior corticosteroid prescribed: _____

*Date prescribed: _____

*Anticipated date of treatment with ILUVIEN: _____

***ILUVIEN HISTORY**

*Has patient previously received ILUVIEN?

☐ No ☐ Yes

*If yes, please provide dates:

	OD	OS
*Date:		
*Date:		
*Date:		
*Date:		

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):** _____

Patient must sign and date the Patient Authorization and Notice of Release of Information on page 2 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 HIPAA AUTHORIZATION TO DISCLOSE/USE HEALTH INFORMATION

Authorization of Uses and Disclosures: I hereby authorize and direct (1) all of the health care providers and pharmacies involved in my care and treatment, as well as their employees, office staff, and agents including affiliated health care practitioners (collectively "Providers"), (2) health care plans and insurers (collectively "Insurers") to use and disclose my "protected health information" ("Information"), as described below, to Alimera Sciences and its representatives (including RxCrossroads) and contractors (collectively "Alimera"). I also expressly authorize all the uses and disclosures described herein where the Information is provided to Alimera by me.

Description of Information: I understand that my Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical information, including information about my health condition and related medical conditions and treatment with ILUVIEN, medical records, and financial information (including information about my insurance) as well as other personal information collected by Providers and/or Insurers about me or otherwise provided by me to Alimera.

Purposes: I authorize and direct Providers and/or Insurers to use and disclose my Information to Alimera for the following purposes: (1) Operating and administrating the AccessPlus Program; (2) Reviewing and providing assistance in connection with my health care plan coverage for ILUVIEN; (3) Applying to the AccessPlus Patient Assistance Program; (4) Determining eligibility for alternative forms or coverage and sources of funding; (5) For administrative purposes of Alimera, such as tracking my use of ILUVIEN.

Remuneration: I understand that my specialty pharmacy provider may receive remuneration from Alimera in connection with this Authorization and the disclosure of my Information per this Authorization.

Expiration: Unless revoked, this Authorization will expire three (3) years from the date signed below.

Revocation: I understand that I have the right to revoke this Authorization by requesting this in writing to Alimera Sciences, AccessPlus, c/o CareMetx, 610 Crescent Executive Court, Suite 200, Lake Mary, FL 32746 or faxed to 844-501-7161, however, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.

Treatment not Conditioned; Signing is Voluntary: I understand that neither Providers, Insurers nor Alimera will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization. However, if I choose not to sign, Alimera will not be able to help me with the AccessPlus program.

Potential for Redisclosure: I understand that Information disclosed pursuant to this Authorization may be redisclosed by Alimera and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA), a federal privacy law.

Copy: I understand that I will be provided with a copy of this signed Authorization if requested.

PATIENT AUTHORIZATION

☐ ***I hereby certify that I am over the age of 18 and have read the foregoing and fully understand the contents.**

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.

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FINANCIAL ASSISTANCE

FINANCIAL ASSISTANCE

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

*Social Security #:_____– _____– _____

*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.

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 3 years from the date set forth below with my signature.

PATIENT AUTHORIZATION

☐ ***I hereby certify that I am over the age of 18 and have read the foregoing and fully understand the contents.**

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

[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 2 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.**

Alimera

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