OMIDRIA**Assure**®

SUPPORT AT EVERY STEP

Instructions for enrolling in the Equal Access Patient Assistance Program

For the Patient

1. Complete all relevant fields on the Patient Enrollment Form (reverse side of this page)
2. Sign the Patient Certification (reverse side of this page)

For the Facility

3. Complete all relevant fields on the Patient Enrollment Form and sign the Physician Certification (reverse side of this page)
4. Fax completed form with legible copies of each applicable insurance card, front and back, to **+1-855-616-7741**
5. Form must be completed and approved 5 days before surgery

If your patient meets the eligibility criteria for the Equal Access Patient Assistance Program, OMIDRIA® (phenylephrine and ketorolac intraocular solution) 1% / 0.3% will be provided at no cost for use during your patient's surgery.

FOR PERSONALIZED HELP, CALL THE LIVE ASSISTANCE REIMBURSEMENT HOTLINE AT **1-877-OMIDRIA (1-877-664-3742)**, 9AM–5PM ET, MONDAY-FRIDAY

OMIDRIA®
(phenylephrine and ketorolac intraocular solution)
1% / 0.3%

Patient Enrollment Form

OMIDRIAssure®
SUPPORT AT EVERY STEP

The top section of the form (above the line) should be completed and signed by the patient or patient's legal representative. The bottom section of the form (below the line) should be completed and signed by the physician prior to surgery. A printout of the patient's electronic medical record may be substituted for relevant sections of this form.

PATIENT INFORMATION (Note: only US residents are eligible)

First Name _____ Last Name _____

Date of Birth _____ Address (not PO box) _____

City _____ State _____ Zip Code _____

FINANCIAL INFORMATION (used to evaluate request for patient assistance)

Total Number of People in Household (including Patient) _____

Total Yearly Household Income (including salary/wages; Social Security income; disability income; any other income)* _____

*Supporting documentation may be requested.

PATIENT CERTIFICATION

By signing below I certify that the information I have provided on this application and any supporting documentation that I may provide are complete and accurate, and I authorize my physician to release to OMIDRIAssure® any information necessary to evaluate my eligibility for the Equal Access Patient Assistance Program. I agree that OMIDRIAssure representatives may review and verify my eligibility for the Equal Access Patient Assistance Program and that they may contact me or my physician for additional information. I also agree that, if requested, I will provide proof of my stated income or any other eligibility requirement in a timely manner. I understand that Rayner Surgical Inc. may change or terminate OMIDRIAssure and/or the Equal Access Patient Assistance Program at any time.

Signature of Patient or Patient's Legal Representative _____

Printed Name _____ Date _____

Relationship to Patient (if Patient's Legal Representative) _____

This section of the form should be completed by the physician.

PATIENT INSURANCE INFORMATION

Does the patient have medical and/or prescription benefits through any private commercial or government health insurance program? (If yes, please provide a legible copy of each applicable insurance card.) Yes ☐ No ☐

PHYSICIAN INFORMATION

Physician Name _____ NPI No./DEA No. _____

Patient Diagnosis ICD-9/ICD-10 Code(s) _____

Procedure Code CPT Code _____ Date of Surgery _____

Facility/Practice Name _____

Address (not PO box) _____ City _____

State _____ Zip Code _____ Phone _____ Fax _____

Site Contact Name _____

PHYSICIAN CERTIFICATION

My signature below certifies that the patient named above is my patient and that the information provided is, to the best of my knowledge, complete and accurate. I have obtained the patient's authorization to disclose his or her personal and health information to the OMIDRIAssure program to use and to disclose as necessary in connection with the possible provision of patient and/or reimbursement support services. If the patient is uninsured or insured by a government insurance program and is eligible for the Equal Access Patient Assistance Program, I agree that OMIDRIA®, provided at no cost, will be used only for the patient named on this form and will not be offered for sale, trade, or barter and that no claim for reimbursement of OMIDRIA will be submitted to Medicare, Medicaid, or any other third-party payer. I consent to Rayner Surgical Inc. representatives and agents contacting me to confirm receipt of OMIDRIA or to provide additional information about OMIDRIA and the OMIDRIAssure program. I agree that Rayner Surgical Inc. may change or terminate any of the OMIDRIAssure program services at any time without notice.

Signature of Physician _____ Date _____

Dispense: OMIDRIA 4-mL vial	Qty 1	Sig: Dilute 4 mL of OMIDRIA in 500 mL of ophthalmic irrigation solution. Must be administered by, or under the supervision of, a physician.	Refills: 0

Fax completed and signed form to +1-855-616-7741

For Indications and Important Safety Information, please read the Full Prescribing Information at www.omidriahcp.com/prescribinginformation.

Rayner

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1% / 0.3%