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: ____________

Please complete the following patient information OR attach EMR Face/Demographic Sheet to this enrollment. Important Note: You must complete the patient first and last name on the form.

☐ **EMR Face/Demographic Sheet Attached**

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

Primary Language: ____________ *Primary Phone Number: (   ) ________ Secondary Phone Number: (   ) ________

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

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

INSURANCE INFORMATION

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 Name: ____________ ☐ Medicare ☐ Medicare Advantage ☐ Commercial/Private ☐ Medicaid ☐ Other:

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

PRESCRIBER & OFFICE INFORMATION

***Prescribing Physician First Name:** ____________ ***Last Name:** ____________ ***NPI #:** ________

***This patient will be injected (Place of Service):** ☐ Physician Office ☐ Hospital Outpatient ☐ Ambulatory Surgery Center

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

Hospital or ASC Tax ID #: ____________

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

(If SP is available per the benefits investigation, a pre-populated prescription referral form will be included with the Summary of Patient Benefits).

Primary Office Contact for this Patient Enrollment:

Name: ____________ Phone: (   ) ________ Email: ____________

***Fax benefit investigation results to:** (   ) ________

TREATMENT INFORMATION AND PATIENT HISTORY

Diabetic Macular Edema (DME)

Type 1 diabetes with...

Rt	Lt	ICD-10-CM	
☐	☐	E10.311	(unspecified diabetic retinopathy [DR] with macular edema [ME])
☐	☐	E10.321	(mild nonproliferative DR with ME)
☐	☐	E10.331	(moderate nonproliferative DR with ME)
☐	☐	E10.341	(severe nonproliferative DR with ME)
☐	☐	E10.351	(proliferative DR with ME)

Type 2 diabetes with...

Rt	Lt	ICD-10-CM	
☐	☐	E11.311	(unspecified DR with ME)
☐	☐	E11.321	(mild nonproliferative DR with ME)
☐	☐	E11.331	(moderate nonproliferative DR with ME)
☐	☐	E11.341	(severe nonproliferative DR with ME)
☐	☐	E11.351	(proliferative DR with ME)

Diabetes due to underlying condition with...

Rt	Lt	ICD-10-CM	
☐	☐	E08.311	(unspecified DR with ME)
☐	☐	E08.321	(mild nonproliferative DR with ME)
☐	☐	E08.331	(moderate nonproliferative DR with ME)
☐	☐	E08.341	(severe nonproliferative DR with ME)
☐	☐	E08.351	(proliferative DR with ME)

Drug- or chemical-induced diabetes with...

Rt	Lt	ICD-10-CM	
☐	☐	E09.311	(unspecified DR with ME)
☐	☐	E09.321	(mild nonproliferative DR with ME)
☐	☐	E09.331	(moderate nonproliferative DR with ME)
☐	☐	E09.341	(severe nonproliferative DR with ME)
☐	☐	E09.351	(proliferative DR with ME)

Other specified diabetes with...

Rt	Lt	ICD-10-CM	
☐	☐	E13.311	(unspecified DR with ME)
☐	☐	E13.321	(mild nonproliferative DR with ME)
☐	☐	E13.331	(moderate nonproliferative DR with ME)
☐	☐	E13.341	(severe nonproliferative DR with ME)
☐	☐	E13.351	(proliferative DR with ME)

Other code(s): ____________

TREATMENT INFORMATION AND PATIENT HISTORY

Date of Primary Diagnosis:

Anticipated Date of Treatment:

Prior Corticosteroid Treatment

Medication Prescribed:

Date of Treatment:

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

FINANCIAL ASSISTANCE

ILUVIEN CoPay Program and Foundation Co-Pay Assistance:

Preferred Foundation Assistance Program:

Select one: ☐ Chronic Disease Fund (CDF) or ☐ Patient Access Network Foundation (PANF)

Select one: ☐ Approved ☐ Application in process ☐ Please contact patient to initiate application ☐ Our office will handle foundation assistance

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

Patients with commercial insurance are eligible for the ILUVIEN CoPay Program.[1] ***Household income and number in household are required for program approval.*** (You and the patient will receive a letter of approval upon providing this information).

PATIENT AUTHORIZATION

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

☐ Patient has signed Patient Authorization and Notice of Release of Information (page 2) and it is attached.

☐ Patient signed Patient Authorization and Notice of Release of Information within the prior 12 months and it is on file with AccessPlus.

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.

[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.

accessplus
Reimbursement and Patient Assistance

ILUVIEN®
(fluocinolone acetonide intravitreal implant) 0.19mg

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 Alimera Sciences and our representatives' administrative purposes.

This authorization and notice of release is effective for 1 year 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 sign and date here

First Name | **Middle Initial** | **Last Name**

If signing for the patient, you must print your name here

Name of Legally Authorized Person | ( ) **Contact Phone**

US-ILV-MMM-0044-04 9/15

Please fax completed Patient Enrollment to AccessPlus at 1.844.501.7161.

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