RETISERT™ Reimbursement and Patient Assistance Program

Please complete each section to the fullest extent possible. Return this completed confidential application to:

RETISERT™ Assistance Program
PO Box 220827
Charlotte, NC 28222-0827
Telephone: 866-250-2974 Fax: (866) 250-2975

Physician Statement of Medical Necessity for Financially Needy Patients

To the best of my knowledge, this patient has no medical coverage (including Medicaid or other public programs) for RETISERT.

☐ TRUE ☐ FALSE

PATIENT INFORMATION

☐ **Benefit Verification Request** ☐ **Patient Assistance Request**

Patient Name: _____

SS# : _____

Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

For confidentiality purposes, please indicate the number at which you would prefer to be contacted.

Home: (_____)_____ Work: (_____)_____

INSURANCE INFORMATION

Preferred Option for Obtaining Retisert :

Bill Patient through Specialty Pharmacy
Physician/ Facility Purchase and Bill

Primary Insurance

Health Insurance Company:_____

Telephone:(_____)_____ Contact Person:_____

Policy ID # : _____Group # :_____

Subscriber Name: _____Date of Birth:_____

Prescription Card # : _____ Carrier:_____

Do you have any **secondary insurance**, including **Medicare**?

☐ YES ☐ NO _____

FINANCIAL INFORMATION (Patient Assistance only)

Current annual household income $_____

Do you receive social security income (SSI)? ☐ YES ☐ NO

Number of household members dependent on income stated above (include applicant)_____

APPLICANT DECLARATION (Patient Assistance only)

I verify that the information provided in this application is complete and accurate. I further understand that the RETISERT Patient Assistance Program may request documentation to verify financial or insurance information. *I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that Bausch & Lomb reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.*

I authorize my healthcare providers to release to the RETISERT Patient Assistance Program (Bausch & Lomb and their agents) medical information necessary to secure or establish health insurance coverage. I authorize the RETISERT Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application. I agree that if I am eligible and receive any free product that I will not submit a claim to seek reimbursement from my health care insurer for such free product

Patient Signature_____ Date_____

PHYSICIAN INFORMATION

Physician Name: _____

NPI# _____DEA # _____

Tax ID # /Provider ID# _____

State License # _____

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____

Office Contact Name_____

SHIPPING INFORMATION

Financially needy patients eligible for product assistance will receive free product shipped to the address indicated below.

Ship Retisert to: ☐Physician Office ☐Hospital/Clinic ☐Amb Surg Ctr

Hospital/Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Delivery Contact Name/Dept: _____

Tel: _____ Fax: _____

CLINICAL INFORMATION

For which eye(s) does the patient require RETISERT

☐ Left Eye ☐ Right Eye ☐Bilateral

Desired date of surgery: _____

Site of Service: _____

Diagnosis:

- ☐ 363.20 Uveitis, posterior (Chorioretinitis, unspecified)
- ☐ 136.1 Behçet's disease
- ☐ 360.11 Sympathetic uveitis
- ☐ 360.12 Panuveitis
- ☐ 362.18 Retinal vasculitis
- ☐ 363.00 Focal chorioretinitis, unspecified
- ☐ 363.10 Disseminated chorioretinitis, unspecified
- ☐ 363.12 Disseminated choroiditis and chorioretinitis, peripheral
- ☐ 364.24 Vogt-Koyanagi syndrome
- ☐ 363.54 Central choroidal atrophy, total
- ☐ Other _____

By signing below I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above referenced information and other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPPA)) to Bausch and Lomb's RETISERT Reimbursement Support Team and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy, and/ or the evaluation of the patient's eligibility for the Bausch & Lomb's Patient Assistance Program, and (c) I appoint the RETISERT Reimbursement Support Team solely to convey on my behalf to the pharmacy dispensing the above named patient's prescription described herein.

PhysicianSignature_____Date_____

Prescription Information for Retisert