FOCUS ON ACCESS™

Patient Information and Enrollment Form

Complete and fax this form to 866-272-8839.
For assistance, call 866-272-8838, Monday-Friday, 9:00 AM-5:00 PM, ET

BAUSCH + LOMB

1. PATIENT INFORMATION (REQUIRED)

NAME (First, MI, Last) _____ DOB (MM/DD/YYYY) _____ SEX ☐ M ☐ F

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

E-MAIL _____ CELL _____

HOME PHONE _____ WORK PHONE _____

PREFERRED NUMBER TO CALL ☐ Cell ☐ Home ☐ Work BEST TIME TO CONTACT ☐ Morning ☐ Afternoon ☐ Evening

2. INSURANCE INFORMATION (REQUIRED)

☐ ENLARGED COPY OF INSURANCE CARD(S) ATTACHED ☐ NO INSURANCE

PRIMARY INSURANCE _____

CARDHOLDER _____ RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY # _____ GROUP # _____ MEMBER ID # _____

SECONDARY INSURANCE _____

CARDHOLDER _____ RELATIONSHIP TO CARDHOLDER _____

EMPLOYER _____ INS. CO. PHONE _____

POLICY # _____ GROUP # _____ MEMBER ID # _____

3. PATIENT AUTHORIZATION (Patient should read this Patient Authorization and sign below.)

I authorize my health care providers and health plans to disclose my protected health information ("PHI") to agents, representatives and employees of Bausch Health US, LLC (Bausch + Lomb) to: (1) establish my eligibility for benefits through the FOCUS ON ACCESS™ (FOA) program; (2) communicate with my health care providers and me about my medical care; and (3) provide support services including facilitating the provision of product to me. I understand that once my PHI has been disclosed to Bausch + Lomb federal privacy laws may no longer restrict its further disclosure. Bausch + Lomb agrees to use and disclose this information only for the above purposes and as permitted by law. I further understand I may refuse to sign this authorization and that my health care providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I may cancel this authorization by notifying Bausch + Lomb in writing and submitting the cancellation by fax to: 1-866-272-8839. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.

_____

Signature of Patient/Personal Representative Date

_____

Print Name of Patient Personal Representative Relationship to Patient (if applicable)

4. PRESCRIBER INFORMATION (REQUIRED)

PRESCRIBER NAME (First, Last) _____ SPECIALTY _____

PRACTICE NAME _____ OFFICE CONTACT _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

E-MAIL _____ PHONE _____ FAX _____

MEDICAID/MEDICARE PROVIDER # _____ TAX ID # _____ STATE LICENSE # _____ UPIN/NPI # _____

5. CLINICAL INFORMATION

PRODUCT REQUEST–CHECK SELECTION

☐ Retisert® (fluocinolone acetonide intravitreal implant) 0.59 mg

☐ Visudyne® verteporfin for injection

☐ XIPERE™ (triamcinolone acetonide injectable suspension) 40 mg/mL

☐ Left Eye ☐ Right Eye ☐ Bilateral Diagnosis/ICD-10 Code(s): _____

6. PLACE OF SERVICE

☐ Physician Office ☐ ASC ☐ HOPD

FACILITY NAME _____ FACILITY PHONE _____ FACILITY FAX _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Please see accompanying full Prescribing Information for RETISERT®, VISUDYNE®, and XIPERE™, also available at https://www.bauschretinarx.com.