Prescription Information and Enrollment Form

BAUSCH + LOMB

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

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 PRESCRIPTION CARD(S) ATTACHED ☐ NO INSURANCE

PRESCRIPTION INSURER ____ PHONE ____

BIN # ____ MEMBER ID # ____

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.

PATIENT AUTHORIZATION

I authorize my healthcare 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 ____ OFFICE CONTACT ____

PRACTICE NAME ____

ADDRESS ____

CITY ____ STATE ____ ZIP CODE ____

E-MAIL ____ PHONE ____ FAX ____

MEDICAID/MEDICARE PROVIDER # ____ TAX ID # ____

STATE LICENSE # ____ UPIN/NPI # ____

5. PRESCRIPTION CLINICAL INFORMATION

PRODUCT(S) REQUEST–CHECK SELECTION

☐ **Retisert® (fluocinolone acetonide intravitreal implant) 0.59mg**
☐ **Visudyne® (verteporfin for injection)**

☐ Left Eye ☐ Right Eye ☐ Bilateral:

Diagnosis/ICD-10 Code: ____

6. PHYSICIAN CERTIFICATION

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE (NO STAMPS ALLOWED): I attest that the information provided is current, and accurate to the best of my knowledge. I certify that product is medically necessary for this patient and I will be supervising the patient's treatments. I have obtained from my patient all required authorizations for the release to agents and representatives of Bausch Health US, LLC (Bausch + Lomb) of my patient's identification and insurance information. I understand that any information provided is for the sole use of Bausch + Lomb and its agents and representatives to verify my patient's insurance coverage and to assess, if applicable, patient's eligibility for participation in the patient assistance program ("PAP") and to otherwise administer the FOA program. I understand that application to the PAP does not guarantee that assistance will be obtained. I understand that if my patient's insurance status changes, he/she may no longer be eligible for the PAP, and I agree to immediately notify FOA if I become aware of such a change in status. I certify that I will not bill for or accept payment from patients (or any third party), in whole or in part, for product obtained through the PAP. I agree that if a retroactive insurer claim decision or policy change results in reimbursement to me for product supplied through the PAP, I will immediately notify a FOA representative, and I understand that in such event Bausch + Lomb will bill me for the reimbursement product, and I agree to be responsible for payment of the bill. I understand that I am under no obligation to prescribe product and that I have not received nor will I receive any benefit from Bausch + Lomb or its agents or representatives for prescribing product.

SIGNATURE ____

Date

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