

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 # _____ UPI/NPI # _____

5. CLINICAL INFORMATION

PRODUCT REQUEST—CHECK SELECTION

Retisert®
(fluocinolone acetonide
intraocular 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>.

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