OXERVATE PATIENT ENROLLMENT FORM

INSTRUCTIONS:

- **Complete all pages of this form for each new prescription. Please print.**
- **Please fax completed form to Dompé CONNECT to Care at 1-855-263-1775, phone 1-877-422-4412.**
- **Please provide copies of front and back of all insurance cards.**

PATIENT INFORMATION

Name (Last, First, Middle Initial): _____ Date of Birth: _____

Address: _____ City: _____ State: _____ ZIP: _____

Preferred Phone: _____ Alternative Phone: _____ Best Time to Call: ☐ Day ☐ Evening

Patient Email: _____ Preferred Language: _____

SSN (last 4 digits): _____ Gender: ☐ Male ☐ Female

Caregiver Contact Name: _____ Caregiver Contact Phone Number: _____

Okay to leave message with alternate caregiver/contact? ☐ Yes ☐ No

TREATMENT INFORMATION/PRESCRIPTION (physician to fill out)

Treated Eye (select one): ☐ Left ☐ Right ☐ Both eyes **Stage (select one):** ☐ Mild (Stage 1) ☐ Moderate (Stage 2) ☐ Severe (Stage 3)

Check all ICD-10 codes that apply to the treated eye(s):

ICD-10 Codes Check all that apply	Central corneal ulcer	Unspecified corneal ulcer	Neurotrophic Keratoconjunctivitis	Anesthesia and hypoesthesia of cornea	Other
Right eye	☐ H16.011	☐ H16.001	☐ H16.231	☐ H18.811	☐ _____
Left eye	☐ H16.012	☐ H16.002	☐ H16.232	☐ H18.812	☐ _____

Product: OXERVATE (cenegermin-bkbj) ophthalmic solution 0.002% (20 mcg/mL),x8 units* **NDC Code:** 71981-020-07

Description: The OXERVATE prescription is for 8 weeks, with weekly quantities being dispensed in a single package. Each weekly package contains 7 multi-dose daily vials and a device system kit (NDC- 71981-001-01).

Unilateral: Instill one drop of OXERVATE in the affected eye, 6 times a day at 2-hour intervals for 8 weeks.
Bilateral: Instill one drop of OXERVATE in each eye, 6 times a day at 2-hour intervals for 8 weeks.*

*If both eyes are affected (bilateral) then this prescription is valid for two 8-week treatments. Two vials will be used per day (1 vial for each affected eye).

Contact lenses should be removed before applying OXERVATE and may be reinserted 15 minutes after administration. If a dose is missed, treatment should be continued as normal, at the next scheduled administration.

If more than one topical ophthalmic product is being used, administer the eye drops at least 15 minutes apart to avoid diluting products. Administer OXERVATE 15 minutes prior to using any eye ointment, gel, or other viscous eye drops.

Click here for more information about the US Prescribing Information (https://oxervate.com/pdf/PrescribingInformation.pdf)

Prescriber Signature: (dispense as written) _____ **No refills**

Prescriber Signature: (substitution allowed) (no stamps) _____ Date _____

This document and signature authorizes the transmission of all necessary information for the prescription to the dispensing pharmacy. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. For New York prescribers: In addition to this completed form, provide New York–specific prescription blanks.

PRESCRIBING PHYSICIAN INFORMATION

Prescriber (First and Last Name and Title): _____ If APRN, PA or R.Ph. Supervising Physician: _____

NPI Number: _____ Site/Facility Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

State License #: _____ Tax ID #: _____ Medicaid/Medicare Provider #: _____

Office Phone: _____ Office Fax: _____

Preferred method of communication: _____ Office Contact Name: _____

OXERVATE PATIENT ENROLLMENT FORM, continued

PATIENT SUPPORT REQUESTED

Check all Dompé CONNECT to Care programs that apply:

☐ Prior Authorization Assistance

☐ Appeals Support

☐ Financial Assistance by the Dompé Patient Assistance Program

☐ Co-pay Assistance

PATIENT INSURANCE INFORMATION

Primary Insurance Plan (check one): ☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Other

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Insurance Plan Name: _____ Phone Number: _____

Employer: _____ Policy Number: _____ Group Number: _____

Secondary Insurance Plan (check one): ☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Other

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Insurance Plan Name: _____ Phone Number: _____

Employer: _____ Policy Number: _____ Group Number: _____

Prescription Drug Benefit Coverage/Pharmacy Benefit Manager: _____

PATIENT AUTHORIZATION FOR DOMPÉ CONNECT TO CARE

By signing this Authorization, I authorize my health plans, physicians, and pharmacy providers ("Health Plans and Providers") to use and disclose my personal health information or the personal health information of the patient for whom I am the parent, legal guardian, or caretaker relating to his/her medical conditions, treatment, care management, and health insurance for OXERVATE, as well as all information provided on this form and any prescription ("Personal Health Information"), to Dompé U.S. and its representatives, agents, and contractors including, but not limited to, the administrator of Dompé CONNECT to Care (collectively, "Dompé") for the following purposes: (1) to establish eligibility for benefits; (2) to communicate with healthcare providers and me about my medical care; (3) to facilitate the provision of products, supplies, or services by a third party, including, but not limited to, specialty pharmacies; (4) to register me in any applicable product registration program required for my treatment; (5) to enroll me in eligible patient support programs offered by the Dompé CONNECT to Care and/or Dompé U.S., including certain nursing support services (government-reimbursed programs may not be eligible for all support services offered); (6) for me to receive communications from Dompé CONNECT to Care regarding my participation in or experience with the Dompé CONNECT to Care and/or Dompé U.S.

I understand and agree that Health Plans and Providers may receive remuneration from Dompé U.S. in exchange for sharing my Personal Health Information to Dompé. Contractors of Dompé may receive remuneration in exchange for using my Personal Health Information to communicate with me about the Dompé CONNECT to Care services in addition to providing me with therapy support services subsidized by Dompé U.S. I authorize Dompé to use and give out my Personal Health Information to send me information or materials related to OXERVATE (or any other related products or services in which I might be interested), to contact me occasionally to get my feedback (for market research purposes) about OXERVATE or OXERVATE Programs, as required or permitted by law. I understand that my Personal Health Information disclosed under this authorization may be redisclosed by Dompé and is no longer protected by federal privacy laws.

I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this Authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to Dompé CONNECT to Care at 1680 Century Center Pkwy, Suite 4, Memphis TN 38134, but that this cancellation will not apply to any information used or disclosed by my Health Plans and Providers based on this Authorization before they learn that I have cancelled it. This Authorization is valid, for whichever is greater, the duration of taking OXERVATE or ten (10) years from the date signed below or as required by law. A photocopy of this authorization will be treated in the same manner as the original.

☐ I would like to opt out of commercial communications from Dompé CONNECT to Care.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Print Name: _____

PHYSICIAN ENROLLMENT CERTIFICATION

I authorize Dompé U.S., Inc., its affiliates, agents, and contractors (collectively, "Dompé Connect to Care") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. I verify the information I have provided in the enrollment form is complete and accurate to the best of my knowledge. I have obtained the patient's authorization, as indicated below, to disclose his or her health information related to the treatment of OXERVATE to Dompé U.S. and its authorized "Dompé Connect to Care" agents to use and disclose as necessary in the provision of health services or to offer patient care and support services and/or reimbursement support services.

Prescriber Signature: _____ Date: _____