PATIENT ENROLLMENT FORM

DC2C ACCREDO

PHYSICIAN/OFFICE 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.**

*Denotes required field.

PATIENT INFORMATION

Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

*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:

Caregiver Contact Name: Caregiver Contact Phone Number: Okay to leave message with caregiver? ☐ Yes ☐ No

TREATMENT INFORMATION/PRESCRIPTION (physician to fill out)

*ICD-10 Codes Check all that apply to the treated eye(s)	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	☐

This document is provided for informational purposes only and is not legal advice or official guidance from health plans. It is not intended to increase or maximize reimbursement by any health plan. Dompé does not warrant, promise, guarantee, or make any statement that the use of this information will result in coverage or payment for OXERVATE® (cenegermin-bkbj), or that any payment received will cover providers' costs. Dompé is not responsible for any action providers take in billing for, or appealing, OXERVATE claims. This form is to be used post-diagnosis.

***Treated Eye (select one):** ☐ Right ☐ Left ☐ Both eyes

***Stage of Disease:** **Right Eye:** Stage **Left Eye:** Stage

Indication: OXERVATE is indicated for the treatment of neurotrophic keratitis.

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

Description: OXERVATE is supplied in weekly cartons containing 7 multiple-dose vials and a Delivery System Kit (NDC 71981-001-01)

Dosing and Administration: Instill one drop of OXERVATE administered in the affected eye(s), 6 times a day every 2 hours for 8 weeks.
*If both eyes are affected then this prescription is valid for two 8-week treatments. Two vials will be used per day (1 vial for each affected eye).

Important Safety Information

WARNINGS AND PRECAUTIONS

Contact lenses, either therapeutic or corrective, should be removed before applying OXERVATE. Contact lenses may be reinserted 15 minutes after OXERVATE administration.

Eye discomfort, such as eye pain, that can be mild to moderate can occur with OXERVATE. Patients should contact their health care provider if a more serious eye reaction occurs.

ADVERSE REACTIONS

The most common adverse reaction with OXERVATE (~16%) was eye pain. Other adverse reactions with OXERVATE (1% to 10%) included corneal deposits, foreign body sensation, ocular hyperemia, ocular inflammation, photophobia, tearing, and headache.

Please read the full Prescribing Information for OXERVATE at www.OXERVATE.com/prescribing-information.

This document and signature authorize 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. ☐ Check here if this is an e-prescription.

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

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

PRESCRIBING PHYSICIAN INFORMATION

*Prescriber (Title, First Name, Last): If APRN, PA, or RPh Supervising Physician:

NPI Number: *Site/Facility Name:

*Address: *City: *State: *ZIP:

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

*Office Phone: *Office Fax: Office/Account Email:

Preferred Method of Communication: Office Contact Name:

PATIENT ENROLLMENT FORM, continued

*Denotes required field.

PATIENT INSURANCE INFORMATION

Please fill out the following information or attach a copy of the patient's insurance card.

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:

VOLUNTARY PATIENT AUTHORIZATION TO SHARE INFORMATION WITH DOMPÉ

HEALTH INFORMATION CONSENT

As part of our Dompé CONNECT to Care ("DC2C") (the "Services") we collect certain information about your health conditions and diagnoses from you and, with your authorization, your healthcare providers to help us safely provide Services to you. If you choose not to provide this information, we cannot provide our Services. For more information on our data processing practices and rights you may have, please see our Privacy Policy available at https://www.dompe.com/us/privacy-policy/. If you (or your healthcare provider, with your authorization) provide the information and you later change your mind, you may withdraw your consent for future processing or request deletion of your health information at any time by contacting privacy@dompe.com. By signing below, I consent to Dompé U.S. Inc., its affiliates and service providers (collectively "Dompé") collecting and using my health information to provide the Services.

VOLUNTARY PATIENT AUTHORIZATION TO SHARE INFORMATION WITH DOMPÉ

By signing this patient authorization ("Authorization"), I (or the legal guardian or caretaker of such patient on their behalf) hereby authorize my health plans, healthcare providers, healthcare clearinghouses, and their business associates ("Covered Entities," as such term is defined under the Health Insurance Portability and Accountability Act ("HIPAA")) to use and disclose my health information, which may, under some circumstances be considered Protected Health Information ("PHI" as such term is defined under HIPAA) to Dompé (as defined above) including, but not limited to the administrator of the Services (as defined above).

Health information that may be transferred to Dompé includes information related to my medical condition(s), treatment, medications, care management, and health insurance, as well as contact and other information provided on this form and any prescription form. This may include information about sexually transmitted infections, HIV status, substance dependencies or treatments if included in my file and relevant to the purposes described in this form.

By and through this Authorization, I authorize Dompé to use my health information for the following purposes:

1. To establish eligibility for the Services. 2. To communicate with Covered Entities and me about my medical care and coverage. 3. To facilitate, assess, support or improve the provision of Dompé products, supplies, or services, including the Services, provided by Dompé or through a third party, including, but not limited to our access hub(s) or specialty pharmacy(ies). 4. To enroll me in patient or product support programs offered by Dompé or other entities for which I may be eligible based on my health information, including but not limited to any OXERVATE® patient support program, and or certain nursing support services, if available. 5. To use and share my information to send me or cause third parties to send me communications and or information regarding my experience with access to and use of OXERVATE and or other Dompé products or services. Such communications may include survey and other market or clinical research invitations, as well as marketing communications. 6. As otherwise required or permitted by law.

I understand and agree that:

1. Dompé contractors or vendors who receive my health information from Dompé for the purposes listed above may also receive direct or indirect remuneration from Dompé in exchange for their communications with me about Dompé patient or product support programs or support services subsidized by Dompé. 2. Any health information disclosed to Dompé by the Covered Entities pursuant to this authorization will no longer be protected by the Covered Entities' HIPAA obligations but will be kept confidential by Dompé subject to its Privacy Policy (located at: dompe.com/us/privacy-policy), and such privacy laws applicable to Dompé. 3. In the event of a business transaction such as the sale or reorganization of all or part of Dompé's business, my health information may be transferred to a purchaser or successor company to permit the above uses to be continued after the business transaction.

I also understand and acknowledge that:

1. I may refuse to sign this Authorization and that access to Dompé's products and or eligibility for insurance benefits are not conditioned upon my agreement to grant and sign this Authorization. 2. Upon signature, I may request a copy of the signed Authorization. When filled out electronically, I may download a copy of this Authorization or request that this Authorization be emailed to the email address provided. 3. I may revoke this Authorization at any time in writing by mailing a letter to 1680 Century Center Pkwy, Suite 4, Memphis TN 38134, or by email to: DompeConnect2Care@AssistRx.com. Processing of my request to revoke this Authorization may take up to 30 days from the date of receipt to the physical and or email address indicated above, whichever is received first. 4. A request to revoke this Authorization will apply except to the extent that a Covered Entity has already acted and relied on it, and therefore such revocation will not protect any health information used or disclosed to Dompé by the Covered Entities before the date of receipt and processing of my request to revoke the Authorization. 5. Unless earlier revoked, this Authorization will be valid for ten (10) years from the date of my signature below or as otherwise permitted or limited by law. 6. A photocopy or digital copy of this Authorization will have the same force and effect as the original.

Dompé Telephone Consumer Protection Act (TCPA) Authorization

☐ I authorize Dompé, its affiliates and service providers including, but not limited to Dompé's specialty pharmacy(ies), its access hub(s) to send me recurring automated text messages and/or call me using live, artificial or pre-recorded voice messages which may be sent using an automatic telephone dialing system or other similar technology now existing or later developed ("Messages") to provide updates, alerts, educational materials, marketing communications, and or information (e.g., materials or communications related to Dompé and or Dompé products or services, etc.) or to get my feedback (for market research purposes) about OXERVATE or OXERVATE programs, and as otherwise required by law. I consent to the receipt of Messages to the phone number(s) I provided in this form, even if the phone number(s) are registered on any state or federal Do Not Call list. Standard message and data rates may apply. Message frequency varies. I understand that this TCPA consent is valid until revoked and that it is not required to receive goods or services. To unsubscribe from the Messaging program, I may reply STOP to any text message or may email DompeConnect2Care@AssistRx.com. Following such a request to unsubscribe, I consent to receive one additional Message confirming that the request has been processed.

For more information, reply HELP to any Message or contact Dompé at: DompeConnect2Care@AssistRx.com.

*Patient/Guardian Signature: *Date:

*Patient/Guardian Print Name:

PHYSICIAN ENROLLMENT CERTIFICATION

I authorize Dompé U.S., Inc., its affiliates, vendors, agents, and contractors (collectively, "Dompé") to act on my behalf for the limited purposes of transmitting this prescription for fulfillment by a designated pharmacy. I represent that I am acting in compliance with HIPAA and that I have a valid authorization from the patient to disclose his or her health information to Dompé (as defined in this paragraph) in connection with the fulfillment of this prescription, the patient's treatment, and as further detailed in the above Voluntary Patient Authorization. I confirm that the information I have provided in this form is complete and accurate to the best of my knowledge.

*Prescriber Signature: *Date: