EyePoint Assist Patient Enrollment Form

Fax: 1-866-783-3124 | P: 1-833-393-7646, opt 2

YUTIQ® (fluocinolone acetonide intravitreal implant) 0.18 mg

EyePoint ASSIST™

*Indicates Required Field

Patient Information

*First Name: _____ Middle Initial: ___ *Last name: _____

*** YOU MUST COMPLETE THE PATIENT FIRST AND LAST NAME ABOVE.**

Complete the following patient information OR attach EMR face/demographic sheet to this enrollment. ☐ **EMR Face/Demographic Sheet Attached.**

*Date of Birth: _____ *Gender: ☐ Male ☐ Female ☐ Unknown Patient EMR#: _____ Patient Email: _____

Primary Language: _____ *Primary Phone: (___) _____ Secondary Phone: (_____) _____

*Address: _____ *City: _____ *State: ____ *Zip: _____

Alternate Contact: _____ Phone: _____ Permission to contact alternate contact: ☐ Yes ☐ No

Insurance

REQUIRED: Please attach copy of patient's insurance card(s) (front and back) and/or EMR face/demographic sheet to this enrollment.

☐ **Copy of Insurance Card(s) Attached.** ☐ **EMR Face/Demographic Sheet Attached.** ☐ **Patient is uninsured (no third-party or private insurance).**

Primary Insurance: _____ ☐ Medicare ☐ Medicare Advantage ☐ Commercial/Private ☐ Medicaid ☐ Other: _____

Secondary Insurance: _____ ☐ Medicare ☐ Medicare Advantage ☐ Commercial/Private ☐ Medicaid ☐ Other: _____

Prescriber & Office

***Prescribing Physician First Name:** _____ ***Last Name:** _____ ***NPI #:** _____

*Practice/Facility Name: _____ ***State License No.:** _____

*Address: _____ City: _____ State: _____ Zip: _____

Physician Tax ID No.: _____ PTAN No: _____ DEA No. _____

☐ **Buy and Bill** ☐ **Specialty Pharmacy Requested for Dispensing** **Known Drug Allergies** *(required for SP Prescription)*: _____

(Please include a valid prescription if requesting Specialty Pharmacy Dispensing.)

***Primary Office Contact for this Patient Enrollment:** *Name: _____

*Phone: (_____) _____ Email _____ ***Fax benefit investigation results to** : (_____) _____

I would like assistance with submitting completed Plan Restriction paperwork (i.e. Prior Authorization / Pre-Certification / Pre-Determination): ☐ Yes ☐ No

Patient Diagnosis

Noninfectious Posterior Segment Uveitis	Right eye	Left eye	Bilateral
Unspecified focal chorioretinal inflammation	☐ H30.001	☐ H30.002	☐ H30.003
Focal chorioretinal inflammation, juxtapapillary	☐ H30.011	☐ H30.012	☐ H30.013
Focal chorioretinal inflammation of posterior pole	☐ H30.021	☐ H30.022	☐ H30.023
Focal chorioretinal inflammation, peripheral	☐ H30.031	☐ H30.032	☐ H30.033
Focal chorioretinal inflammation, macular or paramacular	☐ H30.041	☐ H30.042	☐ H30.043
Unspecified disseminated chorioretinal inflammation	☐ H30.101	☐ H30.102	☐ H30.103
Disseminated chorioretinal inflammation of posterior pole	☐ H30.111	☐ H30.112	☐ H30.113
Disseminated chorioretinal inflammation, peripheral	☐ H30.121	☐ H30.122	☐ H30.123
Disseminated chorioretinal inflammation, generalized	☐ H30.131	☐ H30.132	☐ H30.133
Acute posterior multifocal placoid pigment epitheliopathy	☐ H30.141	☐ H30.142	☐ H30.143
Posterior cyclitis	☐ H30.21	☐ H30.22	☐ H30.23
Harada's disease	☐ H30.811	☐ H30.812	☐ H30.813
Vogt Koyanagi Syndrome	☐ H20.821	☐ H20.822	☐ H20.823
Other chorioretinal inflammations	☐ H30.891	☐ H30.892	☐ H30.893
Unspecified chorioretinal inflammation	☐ H30.91	☐ H30.92	☐ H30.93

☐ **Other Diagnosis Code(s)** _____ **Description** _____

PRIOR CORTICOSTEROID USE

Please complete this section with the patient's prior corticosteroid treatment history.

Medication Prescribed Date

_____ _____

_____ _____

☐ Patient did not have a clinically significant rise in intraocular pressure

TREATMENT INFORMATION

Anticipated Date of treatment with YUTIQ:

_____

YUTIQ® (fluocinolone acetonide intravitreal implant) 0.18 mg is indicated for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye.

Please see full Prescribing Information at www.yutiq.com

Remember, ICD-10-CM codes submitted to the payer must accurately describe the diagnosis for which the patient receives YUTIQ treatment, represent codes at the highest level of specificity, and reflect the contents of any clinical notes and/or chart documentation and be included in a letter of medical necessity or prior authorization.

Note: Coverage and coding requirements vary by payer, so be sure to conduct an insurance verification to confirm coverage.

The coding information contained herein is gathered from various resources and is subject to change. This document is intended for reference only. Nothing in this document is intended to serve as reimbursement advice, a guarantee of coverage, or a guarantee of payment for YUTIQ. Third-party payment for medical products and services is affected by numerous factors. The decision about which code to report must be made by the provider/physician considering the clinical facts, circumstances, and applicable coding rules, including the requirement to code to the highest level of specificity. Please refer to your Medicare policy/other payer policies for specific guidance.

Patient must sign and date the Patient Authorization and Notice of Release of Information **on page 3** for this Patient Enrollment Form to be processed

Please fax completed Patient Enrollment to EyePoint Assist at 1-866-783-3124.

*Indicates required field. EyePoint Pharmaceuticals reserves the right to change or cancel the EyePoint Assist Program at any time.

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HEALTH CARE PROVIDER AUTHORIZATION

By signing below, I represent and warrant the following:

• This request has been prepared, in conjunction with the patient, by the physician or physician office identified in this request ("my Practice

• I certify that I, or a physician in my Practice, have determined that the prescribed product is medically appropriate for the patient identified above and that I, or a physician in my Practice, will be supervising the patient's treatment.

• I verify that the information provided is complete and accurate to the best of my knowledge.

• I understand that information concerning program participants may be summarized for statistical or other purposes and provided to EyePoint.

• If the patient receives product through the EyePoint Patient Assistance Program, reimbursement for such product administered to the patient will not be sought from any source.

• I also understand that neither I nor my Practice will receive any reimbursement from Eyepoint, whether for administration fees or otherwise.

• I attest that I have obtained all appropriate patient authorizations and consents to disclose the patient's protected health information, and such other information as may be required, to EyePoint Assist and its agents, to use and disclose as may be necessary to assist in obtaining coverage for the product, initiating therapy, providing treatment support services, and administering the EyePoint Patient Assistance Program.

PHYSICIAN CERTIFICATION: THE EYEPOINT ASSIST COPAY ASSISTANCE PROGRAM (For Buy and Bill Product)

I, a licensed health care professional, certify that I have prescribed the Program Product to the patient indicated on this form in the exercise of my independent medical judgment.

I have read and agree to the Terms and Conditions of the Co-pay Assistance Program. I certify that, to the best of my knowledge, the patient meets the criteria set forth in the Terms and Conditions, and that the information I am providing on this form is true and correct.

I certify that I/my office will not take into account the fact that the patient may receive a benefit from the Copay Assistance Program when determining the amount of any charge(s) to the patient. I certify that I/my office will not charge the patient any fee to complete this form and I/my office will not advertise or otherwise use the Copay Assistance Program as means of promoting my services or the Program Product.

I certify that the claim I submit/my office submits to the patient's private health insurer for payment of the Program Product will have the Program Product listed separately from any claim for medication administration or any other items or services provided to the patient.

I understand that I am/my office is responsible for reporting receipt of Copay Assistance Program benefits to any insurer, health plan, or other third party who pays for or reimburses any part of the medication cost paid for by the Copay Assistance Program, as may be required.

I certify that I/my office will not seek reimbursement for all or any part of the benefit received by the patient through the Copay Assistance Program.

I understand that the patient's benefit received under the Copay Assistance Program will be paid directly to me/my office by the Copay Assistance Program on behalf of my patient. I/my office will apply any amounts received from the Copay Assistance Program to the satisfaction of the patient's obligation for the cost of the Program Product only. If I/my office already received payment from the patient for the patient's share of the cost of the Program Product for which the patient receives a benefit through the Copay Assistance Program, I/my office will refund the amounts received (minus the patient's obligation per administration in accordance with the Program Terms and Conditions) back to the patient.

I understand and agree that the certifications I am providing in this Physician Certification apply to the patient indicated on this form and to any other patient enrolled in the Copay Assistance Program who I treat with the Program Product and any claim I submit/my office submits for Copay Assistance Program benefits on the patient's behalf. I understand that I may be asked to sign a new Physician Certification if the Terms and Conditions of the Copay Assistance Program for the Program Product change.

I certify that I have read and agree to the above authorization and certification.

Physician's original signature: _____ Date: _____

Physician's name (please print): _____

Is physician licensed in Vermont? ☐ Yes ☐ No If yes, provide Vermont license number: _____

To report an adverse event to a specific EyePoint Pharmaceuticals product, including death due to any cause, please contact 1-833-393-7646, opt 1.

If requesting Specialty Pharmacy dispensing, please include a valid prescription or complete the below:

☐ **Prescription Attached**

Drug: YUTIQ® (fluocinolone acetonide intravitreal implant) 0.18 mg **Date:** _____ **Quantity:** _____

Refills: _____ **Directions:** _____

For intravitreal injection by medical professional only

☐ I request this prescription be dispensed as written.

Physician's original signature: _____ Date: _____

**A benefit investigation will be completed to determine if the patients plan allows YUTIQ to be ordered through a specialty pharmacy. If the patients benefit design allows for specialty pharmacy ordering, the patient maybe contacted to provide their Prescription Insurance Card information.*

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Patient Authorization

Financial Assistance

FINANCIAL ASSISTANCE

Please complete this section if patient would like EyePoint Assist to investigate financial assistance options for YUTIQ.

Annual Household Income: $ _____ Number in Household (including patient): _____

Proof of income may be requested for auditing purposes.

EyePoint Copay Program

YUTIQ Copay Program[1]: Patients with commercial or private insurance that covers YUTIQ for the approved indication are eligible for the Copay Program. Patient must be a resident of the United States. The program does not have an income eligibility requirement and there is a maximum assistance level. Patient will pay as little as the first $25 of the copay for YUTIQ. Household income and number in household is required information for program approval. Other terms, conditions, and restrictions may apply.

Program does not include assistance for patient cost share for injection procedure or other costs associated with the administration of YUTIQ.

PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION

EyePoint Assist Program

EyePoint Assist is a free program offered to you from EyePoint Pharmaceuticals. EyePoint Assist works on behalf of you to research and coordinate your health insurance coverage for YUTIQ, assess your out-of-pocket costs associated with YUTIQ based on your health insurance benefit plan, refer you to programs or foundations that may be able to provide assistance to you for the costs of YUTIQ and to assist with determining your eligibility for the EyePoint Assist Copay Program which helps you pay for YUTIQ. We assist people who have a health care plan as well as those who do not.

If you do not have a health care plan, or your plan will not pay for YUTIQ, we may be able to help. If you meet certain financial and medical criteria, we can supply free medication. This is done through the EyePoint Assist Patient Assistance Program.

For us to help, we need to look at, use and disclose your protected health information (PHI). Your health care provider and health care plan can disclose your PHI to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PHI to us, and you are authorizing us to disclose your PHI as necessary to perform services for you. Once you sign this form and it is sent back to us by you or your health care provider on your behalf, we can start to provide these services.

You can choose not to agree to this authorization; however, it is important for you to understand that we cannot provide our services without your authorization. This means you might need to pay for YUTIQ on your own.

Patient Authorization to Disclose/Use Health Information

Please read through this information carefully. If you have any questions, talk to your health care provider's office or call us at 1-833-3937646, Option 2.

I hereby authorize my health care providers, health care plans, insurers or programs that provide me healthcare benefits and any specialty pharmacies to disclose to EyePoint Pharmaceuticals and its representatives (including the Asembia Specialty Pharmacy Network) and contractors (together "the Parties") my protected health information ("PHI"). This includes all of my health records relating to my treatment, information about my health care plan benefits and any information having a bearing on my health or my treatment with YUTIQ.

I understand that my specialty pharmacy provider may receive remuneration from EyePoint Pharmaceuticals in exchange for disclosing to EyePoint Assist my health care plan benefits, including PHI, for treatment with YUTIQ.

My PHI may be used only in these ways: operating and administering of the EyePoint Assist program, reviewing and providing assistance in connection with my health care plan coverage for YUTIQ, applying to the EyePoint Assist Patient Assistance Program, determining eligibility for alternative forms of coverage and sources of funding, coordination of prescription fulfillment through a pharmacy, tracking my use of YUTIQ, and for operation and administrative purposes of EyePoint Pharmaceuticals authorized representatives.

This authorization and notice of release is effective for 3 years from the date set forth below with my signature. Once my PHI is disclosed, I know that my PHI might not be covered by any federal law that restricts the use and disclosure of my PHI. There is no guarantee that my PHI might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release. However, the Parties agrees to protect my PHI by using and disclosing it only for the purposes authorized herein or as required by law.

I know I can choose not to sign this form. I may withdraw authorization at any time and for any reason. This will not affect my eligibility to obtain medical treatment with YUTIQ and will have no impact on my treatment by my health care provider. To withdraw authorization, I must send a written notice to EyePoint Pharmaceuticals. It can be sent by fax to **1-866-783-3124** or by mail to **EyePoint Assist Program, 6000 Park Lane Dr, Pittsburgh, PA 15275**. The Parties shall provide timely notification of my withdrawal (revocation) to my health care providers, health care plans, insurers or programs that provide me healthcare benefits and any specialty pharmacies. Once they receive and process the notice of withdrawal (revocation) of this authorization, they may no longer disclose my PHI to the Parties. However, cancelling this authorization will not affect the Parties ability to use and disclose my PHI that it has already received (unless the laws of my state prevent the Parties from continuing to use and disclose such PHI). This withdrawal goes into effect once it is received by EyePoint Pharmaceuticals. If I do not sign this form or if I withdraw my authorization, Eyepoint Pharmaceuticals will not be able to help me with the EyePoint Assist program.

Patient Authorization

I hereby authorize the use and disclosure of my PHI as described in this Patient Authorization and Notice of Release

Patient Name or Legal Representative	**Signature**	**Date Signed**
If legal representative, Relationship to patient	(_____) _____ Contact Phone of Legally Authorized Person	

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[1] The YUTIQ Copay Program is valid ONLY for patients with commercial (private or non-governmental) insurance. It is not valid for patients who are Government beneficiaries or whose prescription drugs are covered, in whole or in part, under Medicaid, Medicare, a Medicare Part D or Medicare Advantage plan, TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan, or any other state or federal healthcare program. Patients who become Government beneficiaries during their enrollment period will no longer be eligible for the program as of the date they become a Government beneficiary.

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