P: 1-844-445-8843, Option 3
F: 1-844-501-7161

accessplus
Reimbursement and Patient Assistance

ILUVIEN®
(fluocinolone acetonide intravitreal implant) 0.19mg

PATIENT ASSISTANCE PROGRAM (PAP) APPLICATION

All fields on this application are REQUIRED.

PATIENT INFORMATION

Patient First Name: _____ Last Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____ Date of Birth: _____

Primary Phone Number: (_____) _____ Gender: ____ M ____ F US/Puerto Rico Resident ____ Y ____ N

Total Household Income for the Previous Calendar Year: $ _____ Number in Household (Including Patient): _____

PATIENT ATTESTATION AND SIGNATURE

Please Read and Sign the Following Attestation:

I understand that to qualify for free medication, AccessPlus has criteria that must be met, including income. I certify the above statement of my total annual household income for the previous calendar year is true, and I do not have the financial resources or insurance coverage (including Medicaid, Medicare or any public or private assistance programs) to pay for prescription medication.

I know that AccessPlus could ask me for proof of income for my household (examples include: current tax returns, letter from Social Security, W2s, pay stubs, employer letter of income, etc.) for the purpose of an audit. I agree to provide my financial documentation in a timely manner, if so requested. In addition, I will notify AccessPlus immediately if my insurance or income situation changes prior to receiving my medication.

I agree that AccessPlus may verify my eligibility for the Patient Assistance Program. I understand that such verification may include contacting me, or my health care provider, for additional information, and/or reviewing additional financial, insurance, and/or medical information.

In connection with administering the Patient Assistance Program, I understand that AccessPlus may contact me or my health care provider directly to confirm receipt of medication or to provide other information related to the Patient Assistance Program. I also understand that AccessPlus may revise, change or terminate the Patient Assistance program at any time.

I acknowledge that AccessPlus will pursue all appropriate legal remedies, including seeking damages in litigation, in the event it is determined that this certification is false or that the financial attestation is false or inaccurate. By signing this attestation, I certify that the above statement of my annual household income amount is true and accurate, to the best of my knowledge. I understand this application is valid for six months from the date I sign it.

You must sign and date here

_____ _____ _____
Signature of Patient or Legally Authorized Person **Relationship to Patient** **Date Signed**

If signing for the patient you must print your name here

_____ _____
Name of Legally Authorized Person **Contact Phone of Legally Authorized Person**

PRESCRIBER INFORMATION

Prescribing Physician First Name: _____ Last Name: _____

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

Tax ID #: _____ State License #: _____ NPI #: _____

Primary Office Contact for This Application: _____ Phone Number: (_____) _____

To the best of my knowledge, this patient has no insurance coverage for the prescription attached below. I certify that I will not seek payment for any medication dispensed from this program. I understand that one unit of ILUVIEN will be provided if this application is approved..

☐ **I have read and understand the above.**

Prescriber is required to sign here

_____ _____
Prescriber Signature **Date Signed**

PRESCRIPTION

Treatment Eye: (Left or Right): _____ Diagnosis Code (ICD-10): _____

Prior Corticosteroid Treatment: Medication Prescribed: _____ Date of Treatment: _____

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

ILUVIEN® (fluocinolone acetonide intravitreal implant) 0.19 mg. Dispense one (1) implant in one (1) preloaded applicator for intravitreal injection.

Prescriber is required to sign here

_____ _____
Prescriber Signature **Date Signed**

PATIENT AUTHORIZATION

Patient must sign and date the attached Patient Authorization and Notice of Release of Information for this Patient Assistance Program Application to be processed.

☐ Patient has signed Patient Authorization and Notice of Release of Information (page 2) and it is attached.

Please fax BOTH SIDES of this COMPLETED PAP Application to ILUVIEN AccessPlus at 1-844-501-7161.

All fields on this application are REQUIRED. Alimera Sciences reserves the right to change or cancel the ILUVIEN AccessPlus Program at any time.

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PATIENT AUTHORIZATION AND NOTICE OF RELEASE OF INFORMATION

AccessPlus Program

AccessPlus is a free program offered to you from Alimera Sciences. AccessPlus works on behalf of you and your health care provider to research and coordinate your health insurance coverage for ILUVIEN, assess your out of pocket costs associated with ILUVIEN 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 ILUVIEN and to assist with determining your eligibility for the AccessPlus CoPay Program which helps you pay for ILUVIEN. 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 ILUVIEN, we may be able to help. If you meet certain financial and medical criteria, we can supply free medication. This is done through the AccessPlus 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 ILUVIEN 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 1-844-445-8843, Option 3.

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 Alimera Sciences and its representatives (including RxCrossroads) and contractors (together "Alimera") 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 ILUVIEN.

I understand that my specialty pharmacy provider may receive remuneration from Alimera Sciences in exchange for disclosing to AccessPlus my health care plan benefits, including PHI, for treatment with ILUVIEN.

My PHI may be used only in these ways: operating and administering of the AccessPlus program, reviewing and providing assistance in connection with my health care plan coverage for ILUVIEN, applying to the AccessPlus 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 ILUVIEN, and our representatives' administrative purposes.

This authorization and notice of release is effective for 3 years from the date set forth below with my signature. Once I sign this form, 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, Alimera 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 ILUVIEN and will have no impact on my treatment by my health care provider. To withdraw authorization, I must send a written notice to Alimera Sciences. It can be sent by fax to 1-844-501-7161 or by mail to Alimera Sciences, AccessPlus, c/o RxCrossroads, PO Box 5873, Louisville, KY 40205. Alimera 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 Alimera. However, cancelling this authorization will not affect Alimera's ability to use and disclose my PHI that it has already received (unless the laws of my state prevent Alimera from continuing to use and disclose such PHI). This withdrawal goes into effect once it is received by Alimera Sciences. If I do not sign this form or if I withdraw my authorization, Alimera Sciences will not be able to help me with the AccessPlus program.

I understand that I, as the patient or signer, have a right to obtain a copy of this signed authorization and notice of release.

I have read this document or have had it explained to me. By signing this form, I know I am authorizing the release and disclosure of my PHI as discussed above. Please complete all of the information below, and be sure to sign and date this form so that there is no delay in starting the AccessPlus program services.

PATIENT AUTHORIZATION

☐ **I have read and agree to the attached Patient Authorization and Notice of Release.**

You must sign and date here

Signature of Patient or Legally Authorized Person _____ **Relationship to Patient** _____ **Date Signed** _____

You must print patient name here

First Name _____ **Middle Initial** _____ **Last Name** _____

If signing for the patient you must print your name here

Name of Legally Authorized Person _____ **Contact Phone** _____

Please fax BOTH SIDES of this COMPLETED PAP Application to ILUVIEN AccessPlus at 1-844-501-7161.

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