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

accessplus
Reimbursement and Patient Assistance

ILUVIEN®
(fluocinolone acetonide intravitreal implant) 0.19mg

PRESCRIBER ENROLLMENT FORM

***Required field**

PRESCRIBER INFORMATION

*Prescriber First Name: _____ *Last Name: _____

*Practice Name: _____ Specialty: _____

*Tax ID: _____ *State License #: _____ *DEA #: _____

*NPI #: _____ *Group NPI #: _____ *PTAN: _____ *Group PTAN: _____

PRESCRIBER PRIMARY ADDRESS & CONTACT INFORMATION

*Address: _____ Suite: _____

*City: _____ *State: _____ *Zip _____

*Phone: (_____) _____ *Fax: (_____) _____

*Office Contact Name: _____

*Office Contact Phone: (_____) _____ *Office Contact Fax: (_____) _____

*Office Contact Email Address: _____

PRESCRIBER SECONDARY ADDRESS & CONTACT INFORMATION

Address: _____ Suite: _____

City: _____ State: _____ Zip _____

Phone: (_____) _____ Fax: (_____) _____

Office Contact Name: _____

Office Contact Phone: (_____) _____ Office Contact Fax: (_____) _____

Office Contact Email Address: _____

BILLING OFFICE ADDRESS & CONTACT INFORMATION (IF APPLICABLE)

Address: _____ Suite: _____

City: _____ State: _____ Zip _____

Phone: (_____) _____ Fax: (_____) _____

Primary Contact Name: _____

Primary Contact Phone: (_____) _____ Primary Contact Fax: (_____) _____

Primary Contact Email Address: _____

I authorize RxCrossroads® to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use, disclose and receive any protected health information (as defined in 45 CFR 160.103) ("PHI") about any of my patients enrolled with the ILUVIEN AccessPlus Program ("Patients"), including exchanging such information with specialty pharmacies, insurers and nurse agencies/coordinators as needed to perform the following services for me: (i) refer my Patients' prescriptions to the specialty pharmacy and receive information on the status of the dispensing of the prescriptions and related matters; (ii) obtain any benefits information about my Patients for purposes of determining the Patient's insurance coverage for ILUVIEN and related medical services. RxCrossroads may also use and disclose such PHI to assist me with other functions related to my treatment, payment and/or health care operations, and as otherwise permitted or required by law. As my business associate, RxCrossroads is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR 164.504(e)(2)(ii)(A) through (I) and 45 CFR 164.314(a)(2)(i)(A) through (C) regarding business associates, and that it will safeguard any PHI that it obtains on my behalf and will use and disclose this information only as permitted herein. RxCrossroads acknowledges that if it materially breaches its obligations as stated herein, I may terminate its services as stated above and this agreement.

Prescriber is required to sign here

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

_____ _____

Prescriber Signature **Date**

You will need to submit this form only once for each physician who will prescribe ILUVIEN. You will receive a fax confirmation that this physician is actively enrolled in the ILUVIEN AccessPlus Program, a multifaceted program designed to provide support for you and your patients in all aspects of ILUVIEN treatment.

Please fax this completed form to ILUVIEN AccessPlus at 1-844-501-7161.