

PATIENT ENROLLMENT FORM

*Indicates Required Field

PATIENT INFORMATION	*Patient First Name: _____ Middle Initial: _____ *Last Name: _____ *Complete the following patient information OR attach EMR face/demographic sheet to this enrollment. YOU MUST COMPLETE THE PATIENT FIRST AND LAST NAME ABOVE. <input type="checkbox"/> *EMR Face/Demographic Sheet Attached.																																																																																																																		
	*Date of Birth: ____/____/____ *Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female *Patient EMR #: _____ Primary Language: _____ Primary Phone: (____) _____ Secondary Phone: (____) _____ *Address: _____ *City: _____ *State: _____ *Zip: _____ AccessPlus may contact this patient to obtain information relating to this enrollment: <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																		
INSURANCE	*REQUIRED: Please attach copy of patient's insurance card(s) (front and back) and/or EMR face/demographic sheet to this enrollment. <input type="checkbox"/> *Copy of Insurance Card(s) Attached. <input type="checkbox"/> *EMR Face/Demographic Sheet Attached.																																																																																																																		
	*Primary Insurance Plan Name: _____ *ID#: _____ *Group#: _____ *Plan Phone: (____) _____ *Secondary Insurance Plan Name: _____ *ID#: _____ *Group#: _____ *Plan Phone: (____) _____																																																																																																																		
PRESCRIBER & OFFICE INFORMATION	*Prescribing Physician First Name: _____ *Last Name: _____ *NPI #: _____ *Place of Service Zip Code: _____ *Place of Service: <input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Ambulatory Surgery Center *Required for Hospital Outpatient /ASC Place of Service: HOPD or ASC Site Name: _____ HOPD or ASC Tax ID#: _____ <input type="checkbox"/> Specialty Pharmacy Requested for Dispensing Known Drug Allergies (required for SP Prescription): _____ (AccessPlus will fax an ILUVIEN Prescriber Referral form to you for the prescriber's signature so that we may investigate SP availability based on the patient's benefit structure.)																																																																																																																		
	*Primary Office Contact for this Patient Enrollment: *Name: _____ *Phone: (____) _____ *Email: _____ *Fax benefit investigation results to: (____) _____																																																																																																																		
Corticosteroid Prior History	*IMPORTANT: THIS SECTION MUST BE FILLED OUT																																																																																																																		
	*REQUIRED: Please complete this section with the patient's prior corticosteroid treatment history. Prior corticosteroid treatment REQUIRED per the FDA labeled indication for ILUVIEN. *Medication prescribed: _____ _____ *Date prescribed: _____ _____ *Anticipated date of treatment with ILUVIEN: _____ _____																																																																																																																		
PATIENT DIAGNOSIS	*ILUVIEN HISTORY																																																																																																																		
	*Has patient previously received ILUVIEN? <input type="checkbox"/> No <input type="checkbox"/> Yes *If yes, please provide dates: <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 45%;">OD</th> <th style="width: 45%;">OS</th> </tr> </thead> <tbody> <tr> <td>*Date:</td> <td></td> <td></td> </tr> <tr> <td>*Date:</td> <td></td> <td></td> </tr> <tr> <td>*Date:</td> <td></td> <td></td> </tr> <tr> <td>*Date:</td> <td></td> <td></td> </tr> </tbody> </table>				OD	OS	*Date:			*Date:			*Date:			*Date:																																																																																																			
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Patient must sign and date the Patient Authorization and Notice of Release of Information on page 2 for this Patient Enrollment form to be processed.

PATIENT HIPAA AUTHORIZATION TO DISCLOSE/USE HEALTH INFORMATION

Authorization of Uses and Disclosures: I hereby authorize and direct (1) all of the health care providers and pharmacies involved in my care and treatment, as well as their employees, office staff, and agents including affiliated health care practitioners (collectively "Providers"), (2) health care plans and insurers (collectively "Insurers") to use and disclose my "protected health information" ("Information"), as described below, to Alimera Sciences and its representatives (including RxCrossroads) and contractors (collectively "Alimera"). I also expressly authorize all the uses and disclosures described herein where the Information is provided to Alimera by me.

Description of Information: I understand that my Information includes, but is not limited to, my name, date of birth, and other personal information and identifiers (including my address), medical information, including information about my health condition and related medical conditions and treatment with ILUVIEN, medical records, and financial information (including information about my insurance) as well as other personal information collected by Providers and/or Insurers about me or otherwise provided by me to Alimera.

Purposes: I authorize and direct Providers and/or Insurers to use and disclose my Information to Alimera for the following purposes: (1) Operating and administering the AccessPlus Program; (2) Reviewing and providing assistance in connection with my health care plan coverage for ILUVIEN; (3) Applying to the AccessPlus Patient Assistance Program; (4) Determining eligibility for alternative forms or coverage and sources of funding; (5) For administrative purposes of Alimera, such as tracking my use of ILUVIEN.

Remuneration: I understand that my specialty pharmacy provider may receive remuneration from Alimera in connection with this Authorization and the disclosure of my Information per this Authorization.

Expiration: Unless revoked, this Authorization will expire three (3) years from the date signed below.

Revocation: I understand that I have the right to revoke this Authorization by requesting this in writing to Alimera Sciences, AccessPlus, c/o RxCrossroads, PO Box 5873, Louisville, KY 40205 or faxed to 844-501-7161, however, I understand that such revocation will not be effective with respect to Information that has already been used and/or disclosed per this Authorization.

Treatment not Conditioned; Signing is Voluntary: I understand that neither Providers, Insurers nor Alimera will not condition my treatment on signing this Authorization. I can choose not to sign this Authorization. However, if I choose not to sign, Alimera will not be able to help me with the AccessPlus program.

Potential for Redislosure: I understand that Information disclosed pursuant to this Authorization may be rediscovered by Alimera and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA), a federal privacy law.

Copy: I understand that I will be provided with a copy of this signed Authorization if requested.

PATIENT AUTHORIZATION	<input type="checkbox"/> *I hereby certify that I am over the age of 18 and have read the foregoing and fully understand the contents.			
	You must sign and date here	<input type="text"/>	Relationship to Patient	<input type="text"/>
	*Signature of Patient or Legally Authorized Person			*Date Signed
	You must fill this out	<input type="text"/>	<input type="text"/>	<input type="text"/>
	*Patient's First Name	Middle Initial	*Last Name	
If signing for patient, you must fill this out	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Name of Legally Authorized Person		*Contact Phone of Legally Authorized Person	

Patient must sign and date the Patient Authorization and Notice of Release of Information (above) for this Patient Enrollment form to be processed.

Please fax completed Patient Enrollment to AccessPlus at 1-844-501-7161.
*Indicates required field. Alimera Sciences reserves the right to change or cancel the AccessPlus Program at any time.

