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 INFORMATION 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: _____

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.