

PATIENT ENROLLMENT FORM

*Indicates required field.

PATIENT INFORMATION	*Patient First Name: _____ Middle Initial: _____ *Last Name: _____
	*Date of Birth: ____/____/____ *Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other *Patient EMR #: _____
	Primary Language: _____ Primary Phone: (____) _____ Secondary Phone: (____) _____
	*Address: _____ *City: _____ *State: _____ *Zip: _____
*Patient Email: _____ AccessPlus may contact this patient to obtain information relating to this enrollment: <input type="checkbox"/> Yes <input type="checkbox"/> No	
INSURANCE	*REQUIRED: Please attach a copy of the 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 Ins. Plan Name: _____ *ID #: _____ *Group #: _____
	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Commercial/Private <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____ *Plan Phone: (____) _____
*Secondary Ins. Plan Name: _____ *ID #: _____ *Group #: _____	
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Commercial/Private <input type="checkbox"/> Medicaid <input type="checkbox"/> Other: _____ *Plan Phone: (____) _____	
PRESCRIBER & OFFICE INFORMATION	*Prescribing Physician First Name: _____ *Last Name: _____
	*Physician NPI #: _____ State License ID #: _____
	*Place of Service Name: _____ *Place of Service: <input type="checkbox"/> Physician Office <input type="checkbox"/> HOPD <input type="checkbox"/> ASC
	*Place of Service Address: _____
	*City: _____ *State: _____ *Zip Code: _____ *Practice NPI #: _____
	*Practice Tax ID #: _____ PTAN #: _____ DEA #: _____
	*Primary Office Contact Name: _____ *Phone: (____) _____
	*Email: _____ *Fax Benefit Investigation Results to: (____) _____

Prescribing office instructions: This form should be used for both indications of ILUVIEN. Please see directions throughout this form to complete the fields required for the patient's specific diagnosis of either diabetic macular edema (DME) or chronic non-infectious uveitis affecting the posterior segment of the eye (NIU-PS).

TREATMENT DATE	*REQUIRED: Anticipated Date of Treatment With ILUVIEN: _____
-----------------------	--

CORTICOSTEROID HISTORY

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

***IMPORTANT:** This section **MUST** be completed if prescribing ILUVIEN for a DME diagnosis. Prior corticosteroid treatment is required per the FDA-labeled DME indication for ILUVIEN. ILUVIEN is a corticosteroid indicated for the treatment of DME in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure.

*Prior Corticosteroid Prescribed: _____

*Date Prescribed: _____

***FLUCINOLONE ACETONIDE INTRAVITREAL IMPLANT HISTORY**

*Has the patient previously received a flucinolone acetonide intravitreal implant (ILUVIEN or YUTIQ)?

No Yes

*If yes, please provide dates:

	OD	OS
*Date:		
*Date:		
*Date:		
*Date:		

Please see Indications and Important Safety Information on pages 2, 3, and 6 and full [Prescribing Information](#) or visit hcp.iluvien.com.

Patient must sign and date the Patient Authorization and Notice of Release of Information on page 4 for this Patient Enrollment form to be processed.

Please fax completed Patient Enrollment to AccessPlus at 1-844-501-7161.

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

Patient Name (Last, First)

DOB (mm/dd/yyyy)

Prescribing office instructions: Please complete this section if the patient's diagnosis is diabetic macular edema (DME). If the patient's diagnosis is chronic non-infectious uveitis affecting the posterior segment of the eye (NIU-PS), please continue to page 3.

Indication: ILUVIEN is a corticosteroid indicated for the treatment of diabetic macular edema (DME) in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure.

Complete this section for a diabetic macular edema (DME) diagnosis

*DIAGNOSIS	Right Eye	Left Eye	Bilateral
Diabetes mellitus due to underlying condition with...			
Mild nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E08.3211	<input type="checkbox"/> E08.3212	<input type="checkbox"/> E08.3213
Moderate nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E08.3311	<input type="checkbox"/> E08.3312	<input type="checkbox"/> E08.3313
Severe nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E08.3411	<input type="checkbox"/> E08.3412	<input type="checkbox"/> E08.3413
Proliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E08.3511	<input type="checkbox"/> E08.3512	<input type="checkbox"/> E08.3513
Drug- or chemical-induced diabetes mellitus with...			
Mild nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E09.3211	<input type="checkbox"/> E09.3212	<input type="checkbox"/> E09.3213
Moderate nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E09.3311	<input type="checkbox"/> E09.3312	<input type="checkbox"/> E09.3313
Severe nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E09.3411	<input type="checkbox"/> E09.3412	<input type="checkbox"/> E09.3413
Proliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E09.3511	<input type="checkbox"/> E09.3512	<input type="checkbox"/> E09.3513
Type 1 diabetes mellitus with...			
Mild nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E10.3211	<input type="checkbox"/> E10.3212	<input type="checkbox"/> E10.3213
Moderate nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E10.3311	<input type="checkbox"/> E10.3312	<input type="checkbox"/> E10.3313
Severe nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E10.3411	<input type="checkbox"/> E10.3412	<input type="checkbox"/> E10.3413
Proliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E10.3511	<input type="checkbox"/> E10.3512	<input type="checkbox"/> E10.3513
Type 2 diabetes mellitus with...			
Mild nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E11.3211	<input type="checkbox"/> E11.3212	<input type="checkbox"/> E11.3213
Moderate nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E11.3311	<input type="checkbox"/> E11.3312	<input type="checkbox"/> E11.3313
Severe nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E11.3411	<input type="checkbox"/> E11.3412	<input type="checkbox"/> E11.3413
Proliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E11.3511	<input type="checkbox"/> E11.3512	<input type="checkbox"/> E11.3513
Other specified diabetes mellitus with...			
Mild nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E13.3211	<input type="checkbox"/> E13.3212	<input type="checkbox"/> E13.3213
Moderate nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E13.3311	<input type="checkbox"/> E13.3312	<input type="checkbox"/> E13.3313
Severe nonproliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E13.3411	<input type="checkbox"/> E13.3412	<input type="checkbox"/> E13.3413
Proliferative diabetic retinopathy with macular edema	<input type="checkbox"/> E13.3511	<input type="checkbox"/> E13.3512	<input type="checkbox"/> E13.3513

For a chronic NIU-PS diagnosis, please complete page 3.

**IMPORTANT SAFETY INFORMATION
CONTRAINDICATIONS**

- ILUVIEN is contraindicated in patients with active or suspected ocular or periocular infections including most viral disease of the cornea and conjunctiva including active epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella, mycobacterial infections and fungal diseases.
- ILUVIEN is contraindicated in patients with glaucoma who have cup to disc ratios of greater than 0.8.
- ILUVIEN is contraindicated in patients with known hypersensitivity to any components of this product.

WARNINGS AND PRECAUTIONS

- **Intravitreal Injection-related Effects:** Intravitreal injections, including those with ILUVIEN, have been associated with endophthalmitis, eye inflammation, increased or decreased intraocular pressure, and choroidal or retinal detachments. For patients with non-infectious uveitis affecting the posterior segment, hypotony has been observed within 24 hours of injection and has resolved within 2 weeks. Patients should be monitored following the intravitreal injection. Patients may experience temporary blurred vision after injection of the implant.

Please see Indications and Important Safety Information on pages 2, 3, and 6 and full [Prescribing Information](#) or visit hcp.iluvien.com.

Patient must sign and date the Patient Authorization and Notice of Release of Information on page 4 for this Patient Enrollment form to be processed.

Please fax completed Patient Enrollment to AccessPlus at 1-844-501-7161.

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

Patient Name (Last, First)

DOB (mm/dd/yyyy)

Prescribing office instructions: Please complete this section if the patient's diagnosis is chronic non-infectious uveitis affecting the posterior segment of the eye (NIU-PS). If the patient's diagnosis is diabetic macular edema (DME), please go to page 2.

Indication: ILUVIEN is a corticosteroid indicated for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye.

Complete this section for a chronic non-infectious uveitis affecting the posterior segment of the eye (NIU-PS) diagnosis

*DIAGNOSIS	Right Eye	Left Eye	Bilateral	Unspecified
	Intermediate uveitis			
Posterior cyclitis	<input type="checkbox"/> H30.21	<input type="checkbox"/> H30.22	<input type="checkbox"/> H30.23	<input type="checkbox"/> H30.20
Panuveitis				
Panuveitis	<input type="checkbox"/> H44.111	<input type="checkbox"/> H44.112	<input type="checkbox"/> H44.113	<input type="checkbox"/> H44.119
Posterior uveitis				
Unspecified focal chorioretinal inflammation (choroiditis/chorioretinitis - NOS)	<input type="checkbox"/> H30.001	<input type="checkbox"/> H30.002	<input type="checkbox"/> H30.003	<input type="checkbox"/> H30.009
Focal chorioretinal inflammation, juxtapapillary	<input type="checkbox"/> H30.011	<input type="checkbox"/> H30.012	<input type="checkbox"/> H30.013	<input type="checkbox"/> H30.019
Focal chorioretinal inflammation of posterior pole	<input type="checkbox"/> H30.021	<input type="checkbox"/> H30.022	<input type="checkbox"/> H30.023	<input type="checkbox"/> H30.029
Focal chorioretinal inflammation, peripheral	<input type="checkbox"/> H30.031	<input type="checkbox"/> H30.032	<input type="checkbox"/> H30.033	<input type="checkbox"/> H30.039
Focal chorioretinal inflammation, macular or paramacular	<input type="checkbox"/> H30.041	<input type="checkbox"/> H30.042	<input type="checkbox"/> H30.043	<input type="checkbox"/> H30.049
Unspecified disseminated chorioretinal inflammation (chorioretinitis/choroiditis)	<input type="checkbox"/> H30.101	<input type="checkbox"/> H30.102	<input type="checkbox"/> H30.103	<input type="checkbox"/> H30.109
Disseminated chorioretinal inflammation (choroiditis/chorioretinitis), posterior pole	<input type="checkbox"/> H30.111	<input type="checkbox"/> H30.112	<input type="checkbox"/> H30.113	<input type="checkbox"/> H30.119
Disseminated chorioretinal inflammation (choroiditis/chorioretinitis), peripheral	<input type="checkbox"/> H30.121	<input type="checkbox"/> H30.122	<input type="checkbox"/> H30.123	<input type="checkbox"/> H30.129
Disseminated chorioretinal inflammation, generalized	<input type="checkbox"/> H30.131	<input type="checkbox"/> H30.132	<input type="checkbox"/> H30.133	<input type="checkbox"/> H30.139
Unspecified chorioretinal inflammation	<input type="checkbox"/> H30.91	<input type="checkbox"/> H30.92	<input type="checkbox"/> H30.93	<input type="checkbox"/> H30.90
Other chorioretinal inflammation	<input type="checkbox"/> H30.891	<input type="checkbox"/> H30.892	<input type="checkbox"/> H30.893	<input type="checkbox"/> H30.899
Harada disease	<input type="checkbox"/> H30.811	<input type="checkbox"/> H30.812	<input type="checkbox"/> H30.813	<input type="checkbox"/> H30.819
Vogt-Koyanagi syndrome	<input type="checkbox"/> H20.821	<input type="checkbox"/> H20.822	<input type="checkbox"/> H20.823	<input type="checkbox"/> H20.829
Acute posterior multifocal placoid pigment epitheliopathy	<input type="checkbox"/> H30.141	<input type="checkbox"/> H30.142	<input type="checkbox"/> H30.143	<input type="checkbox"/> H30.149

IMPORTANT SAFETY INFORMATION (cont)
WARNINGS AND PRECAUTIONS (cont)

- **Intraocular Pressure (IOP) Increase:** Prolonged use of corticosteroids may result in the development of glaucoma with damage to the optic nerve, defects in visual acuity and fields of vision. Steroids should be used with caution in the presence of glaucoma. Intraocular pressure should be routinely monitored during the course of the treatment.
- **Cataracts:** The use of corticosteroids may result in posterior subcapsular cataract formation.
- **Delayed Corneal Wound Healing:** The use of corticosteroids after cataract surgery may delay healing and increase the incidence of bleb formation.
- **Corneal and Scleral Melting:** Various ocular diseases and long-term use of topical corticosteroids have been known to cause corneal and scleral thinning. Use of ophthalmic corticosteroids in the presence of thin corneal or scleral tissue may lead to perforation of the globe.
- **Bacterial Infections:** Prolonged use of corticosteroids may suppress the host response and thus increase the hazard of secondary ocular infections. Acute purulent or parasitic infections of the eye may be masked or activity enhanced by the presence of corticosteroid medication. If signs and symptoms fail to improve after 2 days, the patient should be reevaluated.
- **Viral Infections:** Use of ocular corticosteroids may prolong the course and may exacerbate the severity of many viral infections of the eye (including herpes simplex). Employment of a corticosteroid medication in the treatment of patients with a history of herpes simplex requires great caution; frequent slit lamp microscopy is recommended.
- **Fungal Infections:** Fungal infections of the cornea are particularly prone to develop coincidentally with long-term local corticosteroid application. Fungus invasion should be suspected in any persistent corneal ulceration where a corticosteroid has been used or is in use. Fungal cultures should be taken when appropriate.

Please see Indications and Important Safety Information on pages 2, 3, and 6 and full [Prescribing Information](#) or visit hcp.iluvien.com.

Patient must sign and date the Patient Authorization and Notice of Release of Information on page 4 for this Patient Enrollment form to be processed.

Please fax completed Patient Enrollment to AccessPlus at 1-844-501-7161.

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

ANI PHARMACEUTICALS 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 ANI Pharmaceuticals and its representatives (including CareMetx, LLC) and contractors (collectively "ANI Pharmaceuticals"). I also expressly authorize all the uses and disclosures described herein where the Information is provided to ANI Pharmaceuticals 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 and/or YUTIQ (fluocinolone acetonide intravitreal implant) ("Product"); 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 ANI Pharmaceuticals.

Purposes: I authorize and direct Providers, Specialty Pharmacies, and/or Insurers to use and disclose my Information to ANI Pharmaceuticals 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 Product; (3) Applying to the ANI Pharmaceuticals, Inc. Rare Disease Patient Assistance Program; (4) Facilitating Product acquisition and tracking/reporting through Specialty Pharmacies; (5) For administrative purposes of ANI Pharmaceuticals, such as tracking my use of Product.

Remuneration: I understand that my specialty pharmacy provider may receive remuneration from ANI Pharmaceuticals 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 ANI Pharmaceuticals, AccessPlus, c/o CareMetx, LLC, 6931 Arlington Road, Bethesda, MD 20814 or faxed to 1-844-501-7161; 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 ANI Pharmaceuticals will condition my treatment on signing this Authorization. I can choose not to sign this Authorization; however, if I choose not to sign, ANI Pharmaceuticals will not be able to help me with the AccessPlus program.

Potential for Redisclosure: I understand that Information disclosed pursuant to this Authorization may be redisclosed by ANI Pharmaceuticals 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	*Signature of Patient or Legally Authorized Person	Relationship to Patient *Date Signed
	You must fill this out	*Patient's First Name _____ Middle Initial _____ *Last Name _____	(_____) _____
	If signing for patient, you must fill this out	Name of Legally Authorized Person _____	*Contact Phone of Legally Authorized Person _____

Please see Indications and Important Safety Information on pages 2, 3, and 6 and full [Prescribing Information](#) or visit hcp.iluvien.com.

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. ANI Pharmaceuticals reserves the right to change or cancel the AccessPlus Program at any time.

FINANCIAL ASSISTANCE

ILUVIEN Co-Pay Program: Patients with commercial or private insurance that covers ILUVIEN for the approved indication are eligible for the program. Patient must be a resident of the United States or a US territory. The Co-Pay Program is not valid for patients who are government beneficiaries or whose prescription drugs are covered, in whole or in part, under Medicare, Medicare Part D or Medicare Advantage, Medigap, Medicaid, TRICARE, VA, DoD, Puerto Rico Government Health Insurance Plan, or any other state or federal health care programs. 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.

Patient will be responsible for the first \$25 of the co-pay for ILUVIEN. The program does not have an income eligibility requirement, and there is no maximum assistance level.

Program does not include assistance for patient cost share for injection procedure or other costs associated with the administration of ILUVIEN. Patient must provide household income and number in household. This program is not valid where prohibited by law, taxed or restricted. ANI Pharmaceuticals, Inc. reserves the right to change or cancel this offer or eligibility terms at any time without notice.

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	*Signature of Patient or Legally Authorized Person	Relationship to Patient *Date Signed
	You must fill this out	*Patient's First Name Middle Initial *Last Name	(_____) _____
	If signing for patient, you must fill this out	Name of Legally Authorized Person	*Contact Phone of Legally Authorized Person

PHYSICIAN AUTHORIZATION

My signature certifies the following: (i) The person named on this Patient Enrollment Form is my patient, (ii) I have secured the patient's written authorization and certification using the AccessPlus Patient Enrollment Form, (iii) I will retain in my files a copy of the patient's signed AccessPlus Patient Enrollment Form, (iv) upon request, I will promptly provide AccessPlus with a copy of the patient's enrollment form containing the patient's written authorization, and (v) to the best of my knowledge, the information contained in this form is complete and accurate, including, if applicable, the financial information provided by the patient.

I consent to ANI Pharmaceuticals, Inc. and its affiliates, agents, contractors, and representatives to contact me in person or by phone, fax, mail, or email to provide additional information about ILUVIEN and AccessPlus programs or services. ANI Pharmaceuticals reserves the right to modify or terminate any program or service at any time without notice.

PHYSICIAN AUTHORIZATION	You must sign and date here	*Physician Signature: _____	*Date: _____
	<small>Physician signature required to process all Patient Enrollment Form submissions, including e-Portal or other electronic options.</small>		
	<small>CareMetx public BAA: https://www.caremetx.com/business-associate-agreement</small>		

Please see Indications and Important Safety Information on pages 2, 3, and 6 and full [Prescribing Information](#) or visit hcp.iluvien.com.

Patient must sign and date the Patient Authorization and Notice of Release of Information on page 4 for this Patient Enrollment form to be processed.

Please fax completed Patient Enrollment to AccessPlus at 1-844-501-7161.

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

IMPORTANT SAFETY INFORMATION (cont)

WARNINGS AND PRECAUTIONS (cont)

- **Risk of Implant Migration:** Patients in whom the posterior capsule of the lens is absent or has a tear are at risk of implant migration into the anterior chamber.

ADVERSE REACTIONS

Diabetic Macular Edema

Ocular adverse reactions reported by greater than or equal to 1% of patients in the two combined 3-year clinical trials following injection of ILUVIEN for diabetic macular edema include: cataract (82%), myodesopsia (21%), eye pain (15%), conjunctival hemorrhage (13%), posterior capsule opacification (9%), eye irritation (8%), vitreous detachment (7%), conjunctivitis (4%), corneal oedema (4%), foreign body sensation in eyes (3%), eye pruritus (3%), ocular hyperaemia (3%), optic atrophy (2%), ocular discomfort (2%), photophobia (2%), retinal exudates (2%), anterior chamber cell (2%), and eye discharge (2%). Non-ocular adverse reactions reported by greater than or equal to 5% of patients include: anemia (11%), headache (9%), renal failure (9%), and pneumonia (7%).

Increased Intraocular Pressure: IOP elevation greater than or equal to 10 mm Hg from baseline at any visit was seen in 34% of ILUVIEN patients versus 10% of sham patients. IOP elevation greater than or equal to 30 mm Hg was seen in 20% of ILUVIEN patients versus 4% of sham patients. 38% of the patients who received ILUVIEN were subsequently treated with IOP-lowering medications during the study versus 14% of sham patients. 5% of the patients who received ILUVIEN needed surgical intervention for elevated IOP versus 1% of sham patients.

Cataracts and Cataract Surgery: The incidence of cataract development in patients who had a phakic study eye was higher in the ILUVIEN group (82%) compared with sham (50%). The median time of cataract being reported as an adverse event was approximately 12 months in the ILUVIEN group and 19 months in the sham group. Among these patients, 80% of ILUVIEN subjects versus 27% of sham-controlled subjects underwent cataract surgery, generally within the first 18 months (median month 15 for both ILUVIEN group and for sham) of the studies.

Chronic Non-Infectious Uveitis Affecting the Posterior Segment of the Eye

Ocular adverse reactions reported by greater than or equal to 1% of patients in the three combined clinical trials through 12 months following injection of flucinolone acetonide intraocular implant: cataract (56%), visual acuity reduced (15%), macular edema (11%), uveitis (10%), conjunctival hemorrhage (8%), eye pain (8%), hypotony of eye (7%), anterior chamber inflammation (5%), dry eye (4%), vitreous opacities (4%), conjunctivitis (4%), posterior capsule opacification (4%), ocular hyperemia (4%), vitreous haze (3%), foreign body sensation in eyes (3%), vitritis (3%), vitreous floaters (3%), eye pruritus (3%), conjunctival hyperemia (2%), ocular discomfort (2%), macular fibrosis (2%), glaucoma (2%), photopsia (2%), vitreous hemorrhage (2%), iridocyclitis (1%), eye inflammation (1%), choroiditis (1%), eye irritation (1%), visual field defect (1%), and lacrimation increased (1%). Non-ocular adverse reactions reported by greater than or equal to 2% of patients include: nasopharyngitis (5%), hypertension (3%), and arthralgia (2%).

Increased Intraocular Pressure: IOP elevation greater than or equal to 10 mm Hg from baseline at any visit was seen in 22% of flucinolone acetonide patients versus 12% of sham patients. IOP elevation greater than or equal to 30 mm Hg was seen in 12% of flucinolone acetonide patients versus 3% of sham patients. 43% of the patients who received flucinolone acetonide were subsequently treated with IOP-lowering medications during the study versus 41% of sham patients. 2% of the patients who received flucinolone acetonide needed surgical intervention for elevated IOP versus 2% of sham patients.

Please see Indications and Important Safety Information on pages 2, 3, and 6 and full [Prescribing Information](#) or visit hcp.iluvien.com.

Patient must sign and date the Patient Authorization and Notice of Release of Information on page 4 for this Patient Enrollment form to be processed.

Please fax completed Patient Enrollment to AccessPlus at 1-844-501-7161.

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