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 MUST BE COMPLETED.

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: (_____) _____ Fax 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 PAGES of this COMPLETED PAP Application to ILUVIEN AccessPlus at 1-844-501-7161.

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

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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 administrating the AccessPlus Program; (2) Reviewing and providing assistance in connection with my health care plan coverage of 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 CareMetx, 610 Crescent Executive Court, Suite 200, Lake Mary, FL 32746 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 Redisclosure: I understand that Information disclosed pursuant to this Authorization may be redisclosed 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

You must sign and date here

You must print patient name here

If signing for the patient you must print your name here

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

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

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

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

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

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