FOCUS ON ACCESS™ (FOA) Program Enrollment Form

FOCUS ON ACCESS™ (FOA) helps patients secure access to the following products: Visudyne® (verteporfin for injection), Macugen® (pegaptanib sodium injection), Retisert® (fluocinolone acetonide intravitreal implant) 0.59mg. FOA offers the following services to patients:

Reimbursement Counseling: If requested, FOA counselors will investigate insurance coverage availability for the product prescribed on the enrollment form. FOA counselors can also provide information about: the prior-authorization process, coding questions, claim denials and the appeals process.

Patient Assistance: Subject to eligibility requirements, patients may be considered for the Patient Assistance Program (PAP) if they don't have insurance coverage or the product is not covered by their insurance plan.

Patients without insurance coverage may be provided product at no cost if they meet pre-established eligibility criteria. These include the following:

1. Completed FOA enrollment form (with patient and physician signatures)
    - Once the FOA enrollment form is completed, signed, and returned to FOA, the program can begin to provide product pending validation of patient qualification
2. Documentation of household income
    - Acceptable forms of income documentation include the patient's IRS 1040 form from the most recent tax year, W-2, or Social Security Benefit statement
    - The patient's income documentation must be provided to FOA within 45 days after the enrollment form is submitted to be considered for on-going participation
3. Proof of US residency

Patients who have insurance but whose plans do not cover the product may also be considered for the patient assistance program. To be eligible for assistance through FOA, the patient must meet pre-established eligibility criteria (listed in items 1 through 3 above) and follow the steps set forth in items A through C below:

A. Insurance coverage for the product should be verified by FOA prior to starting treatment (recommended). Prior authorization for the product must have been obtained if required by the insurance company. For Macugen, Retisert and Visudyne only, FOA must be notified by the patient's physician within 60 days after the first claim denial. Enrollment in the program can occur after the initiation of treatment, within 60 days after the first claim denial, however, patients must meet the preestablished criteria to qualify for the program.
B. The patient's physician must ensure appropriate and timely action with the patient's insurance company, including:
    a. Filing a claim form with all the necessary information with the applicable insurer
C. Patient's physician must appeal denied claims and must do so in accordance with insurer's and FOA's Guidelines.

FOCUS ON ACCESS™ Program
PO Box 220662
Charlotte, NC 28222-0662
Phone: (866) 272-8838
Fax: (866) 272-8839

Check Product(s) Requested:
Visudyne® (verteporfin for injection) □
Macugen® (pegaptanib sodium injection) □
Retisert® (fluocinolone acetonide intravitreal implant) *0.59mg* □

FOCUS ON ACCESS™

Enrollment Form

Please complete each section. Return completed application to:
FOCUS ON ACCESS™ - PO Box 220662, Charlotte, NC 28222-0662
Telephone: 866-272-8838 Fax: (866) 272-8839

PATIENT INFORMATION (complete or include demographic sheet)
Patient Name: _____
SS#: _____ DOB_____
Address: _____
City: _____ State: _____ Zip: _____
Day Phone: _____Evening Phone: _____

INSURANCE INFORMATION (complete or include demographic sheet)
Primary Insurance
Health Insurance Company: _____
Telephone: _____
Policy ID #:_____ Group #:_____
Subscriber Name: _____ Date of Birth: _____
Prescription Card #: _____ Carrier: _____
Do you have any **secondary insurance**, including **Medicare**?
__ NO __ YES
Secondary Insurance Company:_____
Telephone: _____
Policy ID#:_____Group#:_____
Subscriber Name:_____

FINANCIAL INFORMATION (Patient Assistance Only)
Current gross annual household income: $_____
Number of members in household: _____
Income Verification Source: __ 1040 __ W-2 Social __ Security Benefit Statement
I, _____ (patient's name) verify that the information provided in this application is complete and accurate. I understand that I must provide proof of income to FOA within 45 days of enrollment in the Patient Assistance Program (PAP). I do not have the financial resources to pay for product. I agree that if I am eligible and receive any free product that I will not submit a claim to seek reimbursement from my health care insurer for such free product. I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that Bausch + Lomb reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.

PATIENT AUTHORIZATION (Required)
I authorize my healthcare providers and health plans to disclose my protected health information ("PHI") to Bausch + Lomb and its agents and contractors ("Bausch + Lomb") to: (1) establish my eligibility for benefits through the Focus On Access™ Program; (2) communicate with my health care providers and me about my medical care; and (3) provide support services including facilitating the provision of product to me. I understand that once my PHI has been disclosed to Bausch + Lomb federal privacy laws may no longer restrict its further disclosure. Bausch + Lomb agrees to use and disclose this information only for the above purposes and as permitted by law. I further understand I may refuse to sign this authorization and that my health care providers and health plans may not condition my enrollment in or eligibility for health plan benefits or my treatment on whether I sign this authorization. I may cancel this authorization by notifying Bausch + Lomb in writing and submitting the cancellation by fax to: 1-866-272-8839. This cancellation will not apply to information that has already been disclosed under this authorization before receipt of the cancellation. I am entitled to a copy of this signed authorization, which expires 10 years from the date it is signed by me.
Patient Signature: _____Date: _____

TO BE COMPLETED BY PHYSICIAN- Physician Information:
Physician Name: _____
NPI#: _____ DEA #: _____
Tax ID #/Provider ID#: _____
State License #: _____
Site/Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Tel: _____ Fax: _____
Contact Name: _____

DELIVERY INFORMATION
(Please indicate shipping address if different from above)
Site/Facility Name: _____
Tax ID #: _____
Address: _____
City: _____ State: _____ Zip: _____
Delivery Contact Name: _____
Tel: _____ Fax: _____

CLINICAL INFORMATION
Left Eye Right Eye Bilateral
Diagnosis (s) _____

PHYSICIAN CERTIFICATION
I attest that the information provided is current, and accurate to the best of my knowledge. I certify that product is medically necessary for this patient and I will be supervising the patient's treatments. I have obtained from my patient all required authorizations for the release to Bausch + Lomb and its agents and representatives of my patient's identification and insurance information. I understand that any information provided is for the sole use of Bausch + Lomb and its agents and representatives to verify my patient's insurance coverage and to assess, if applicable, patient's eligibility for participation in the patient assistance program ("PAP") and to otherwise administer FOA. I understand that application to the PAP does not guarantee that assistance will be obtained. I understand that if my patient's insurance status changes, he/she may no longer be eligible for the PAP, and I agree to immediately notify FOA if I become aware of such a change in status. I certify that I will not bill for or accept payment from patients (or any third party), in whole or in part, for product obtained through the PAP. I agree that if a retroactive insurer claim decision or policy change results in reimbursement to me for product supplied through the PAP, I will immediately notify a FOA representative, and I understand that in such event Bausch + Lomb will bill me for the reimbursement product, and I agree to be responsible for payment of the bill. I understand that I am under no obligation to prescribe product and that I have not received nor will I receive any benefit from Bausch + Lomb or its agents or representatives for prescribing product.
Physician Signature: _____Date: _____

FOCUS ON ACCESS™ (FOA) Program PO BOX 220662 Charlotte, NC 28222-0662 Phone (866) 272-8838 Fax (866) 272-8839	FAX COVER PAGE
To:	Fax Number:
From: Extension:	Date/Time:
Subject:	Pages:

Please note that third-party reimbursement is affected by many factors, and Bausch + Lomb makes no representations or guarantee that you will be successful in obtaining insurance reimbursement or any other payment. This is not intended as a prohibited referral under applicable laws and regulations.

CONFIDENTIALITY NOTICE

The documents accompanying this telecopy transmission contain confidential or privileged information. The information is intended to be for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this telecopied information is prohibited. If you have received this telecopy in error, please notify us by telephone immediately so that we can arrange for the retrieval of the original document at no cost to your office. Thank you for your assistance.

For Physicians:

Check box to confirm your agreement to receiving faxes relating to this enrollment ☐
Physician Fax #: _____