iLink® CROSS-LINKING PROCEDURE

Orsini Specialty Pharmacy

SPECIALTY PHARMACY PROGRAM (SPP) ENROLLMENT FORM

PHONE: 800-550-7207 **FAX:** 877-277-3139

Step 1 Patient Information

Patient First Name: Patient Last Name:
Date of Birth: Gender: M ◯ F ◯
Address: City: State: Zip:
Phone:
Email Address: OK to Send Text (SMS)/Email: Y ◯ N ◯

Parent or Legal Guardian (if applicable) Y ◯ N ◯ Parent or Legal Guardian Phone:
Parent or Legal Guardian First Name:
Parent or Legal Guardian Last Name:

Preferred Language (if not English):

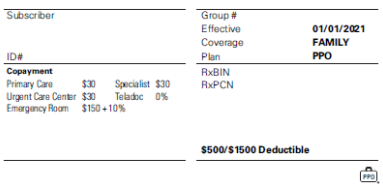
Step 2 Prescriber Information

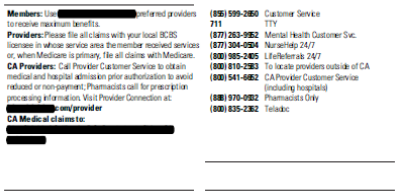
Practice Name:
Physician First Name: Physician Last Name:
Address: City: State: Zip:
Prescriber NPI: Prescriber/Practice Tax ID:
Office Contact Name:
Phone: Fax:
Email:

Step 3 Insurance & Clinical Information

Please include front/back copies of the patient's insurance cards along with relevant clinical documentation to avoid any delays in processing your request.

Example: Insurance Card


Subscriber
ID#
Copayment
Primary Care $30 Specialist $30
Urgent Care Center $30 Teladoc 0%
Emergency Room $150 + 10%
Group #
Effective 01/01/2021
Coverage FAMILY
Plan PPO
RxBIN
RxPCN
$500/$1500 Deductible


Members: Use [redacted] preferred providers to receive maximum benefits.
Providers: Please file all claims with your local BCBS licensee in whose service area the member received services or, when Medicare is primary, file all claims with Medicare.
CA Providers: Call Provider Customer Service to obtain medical and hospital admission prior authorization to avoid reduced or non-payment. Pharmacists call for prescription processing information. Visit Provider Connection at: [redacted].com/provider
CA Medical claims to: [redacted]
(855) 599-2850 Customer Service
711 TTY
(877) 263-9952 Mental Health Customer Svc.
(877) 304-0504 NurseHelp 24/7
(800) 985-2485 LifeBalanceAdv 24/7
(800) 810-2583 To locate providers outside of CA
(800) 541-6652 CA Provider Customer Service (including hospitals)
(888) 970-0982 Pharmacists Only
(800) 835-2382 Teladoc

Please refer to patients plan's documentation requirements for 0402T, these same requirements will be needed for J2787.

Step 4 Prescription Information for iLink® Corneal Cross-Linking Treatment Kit

Each treatment kit includes 1 preloaded 3 mL syringe of Photrexa® (riboflavin 5'-phosphate ophthalmic solution) 0.146% and 1 preloaded 3 mL syringe of Photrexa® Viscous (riboflavin 5'-phosphate in 20% dextran ophthalmic solution) 0.146%. For single-patient use only. For ophthalmic use only.

Eye 1 Anticipated Treatment Date: **Eye 2 Anticipated Treatment Date:**

ICD-10 Diagnosis Code:		Right (1)	Left (2)	Bilateral (3)
H18.62X	Keratoconus, unstable	◯	◯	◯
H18.71X	Corneal ectasia	◯	◯	◯

Sign and date here.
Fax completed form to 877-277-3139

Prescriber's Signature: _____ **Date:** ___/___/___

(Original signature required. This form cannot be processed without a prescriber's signature.)

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Step 5 Patient Consent & Authorization

By signing below, I authorize my healthcare providers, pharmacies, and health insurers to use and to share with Glaukos, Corp., Glaukos Patient Services, and their representatives, agents, and contractors, including Orsini Specialty Pharmacy, Inc. and iPath360 Program (collectively "GPS"), my protected health information ("PHI"). This information can include, for example, my name, SSN, medical and pharmacy records, information relating to my medical condition, treatment, and health insurance, as well as all information provided on any prescription, as it relates to my treatment with Glaukos products. I authorize GPS to use this information for the following purposes: (1) to provide financial support services including benefits verification, potential out-of-pocket costs, and eligibility for financial assistance and/or other patient assistance; (2) to contact me by phone, text, email, or mail to provide product support and related services and obtain feedback; (3) to communicate and exchange PHI with my healthcare providers, pharmacies, and health insurers for reasons related to the Program; (4) to analyze the GPS program and test systems and processes for internal business purposes; and (5) to provide me with information, including promotional and product materials, regarding offers, services, programs, educational training, and ongoing support on the use of Glaukos products that may be of interest to me.

I understand that once my PHI is shared with Glaukos and GPS as described above, it may not remain protected by federal privacy law, including the Health Insurance Potability and Accountability Act ("HIPAA") and could be disclosed to others. I understand that pharmacies may receive payment for the use and disclosure of my PHI as described in this authorization. I further authorize pharmacies to use my PHI to communicate with me about the medicinal product that has been prescribed for me and understand that they may receive a fee for such communication. I understand that some of the use, disclosure, and communication described in this authorization may be for marketing purposes. I understand that I may refuse to sign this authorization and that if I do refuse, it would not affect my rights to treatment or health benefits, but it would prevent me from enrolling in GPS financial and patient assistance programs.

I also understand that I may cancel this authorization at any time by emailing to Glaukos Patient Services at gps@glaukos.com, or by calling 1-833-855-3031 and requesting such cancellation, but that any such cancellation will not affect the sharing of my PHI before my cancellation. If I do not cancel this authorization earlier, it will remain valid for 2 years from the date of my signature below. I understand that I have the right to receive a copy of this authorization when it is signed.

Patient Name or Representative Name (please print):

Relationship to the Patient, including the authority for status as Personal Representative:

Patient's or Representative's Signature: _____

Date:

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