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: Date of Birth:

Patient Last Name: Gender: ◯ M ◯ F

Address: City: State: ZIP:

Check preferred contact method. ◯ Home: ◯ Mobile: ◯ Work: ◯ ***OK to leave message***

Parent or Legal Guardian (if applicable) ◯ Yes ◯ No 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

Physician First Name: Practice Name:

Physician Last Name: Address:

Office Contact Name: City: State: ZIP:

Prescriber NPI: Prescriber/Practice Tax ID:

Check preferred contact method. ◯ Phone: ◯ Fax:

◯ Email:

Step 3 Insurance Information *(Please include front/back copies of patient's insurance cards.)*

Primary Insurance Name: Secondary Insurance Name:

Insurance Phone: Insurance Phone:

Policy ID: Group #: Policy ID: Group #:

Policyholder's First Name: Policyholder's First Name:

Policyholder's Last Name: Policyholder's Last Name:

Policyholder's Date of Birth: Policyholder's Date of Birth:

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.

Anticipated Treatment Date: Treatment Kit Dispense Quantity: ◯ 1 ◯ 2

ICD-10 Diagnosis Code:		Right (1)	Left (2)	Bilateral (3)	Unspecified (9)
H18.62X	Keratoconus, unstable	☐	☐	☐	☐
H18.60X	Keratoconus, unspecified	☐	☐	☐	☐
H18.71X	Corneal ectasia	☐	☐	☐	☐

☐ To facilitate treatment of this patient, I request that Orsini share the information on this enrollment form with the Glaukos Hub for purposes of performing the necessary benefit verification and/or prior authorization for the procedure component (i.e., 0402T, Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed).

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.)

iLink™ CROSS-LINKING PROCEDURE

Orsini Specialty Pharmacy Services

SPECIALTY PHARMACY PROGRAM (SPP) ENROLLMENT FORM

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

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. and its representatives, agents, and contractors, including Orsini Specialty Pharmacy, Inc. and ARCH Program on behalf of Glaukos, Corp., ("Program"), my protected health information ("PHI"), including but not limited to 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 for purposes of providing the services offered by the Specialty Pharmacy Program; including without limitation: (1) financial support services, including benefits verification, potential out-of-pocket costs, and eligibility for financial assistance and/or other patient assistance; (2) providing me with product support and services; (3) communicating and exchanging PHI with my healthcare providers, pharmacies, and health insurers for reasons related to the Program; (4) internal business purposes such as testing systems and processes; (5) providing 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; and (6) contacting me by mail, email, text, telephone, or any other alternative communication method I authorize to discuss Glaukos products and obtain feedback, including for market research purposes. I understand that once my PHI is shared with Glaukos as described above, it may not remain protected by federal privacy law 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 considered use or disclosure for "marketing" under HIPAA. 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 the ARCH Program.

I also understand that I may cancel this authorization at any time by writing to ARCH, 201 Jones Road, 5th Floor, Waltham, MA 02451, or by calling 1-844-528-3311, 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 10 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: