iDose® TR (travoprost intracameral implant) 75 mcg

Orsini Specialty Pharmacy

SPECIALTY PHARMACY PROGRAM (SPP) ENROLLMENT FORM

PHONE: 800-550-7202
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: _____ OK to Send Text (SMS)/Email: Y ☐ N ☐
Email Address: _____
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 & Site of Care Information

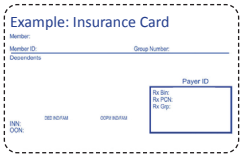
Practice Name: _____
Physician First Name: _____
Physician Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Prescriber NPI: _____
Office Contact Name: _____
Phone: _____
Fax: _____
Email: _____
Prescriber/Practice Tax ID: _____

Site of Care
☐ Office ☐ Ambulatory Surgery Center
☐ Hospital Outpatient Dept. ☐ Other

Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
NPI: _____
Facility Contact Name: _____
Phone: _____
Email: _____
☐ Same as Prescriber

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.



FRONT

BACK


DOCUMENTATION

Please refer to patients plan's documentation requirements for 0660T these same requirements will be needed for (J7355) to its iDose® TR (travoprost intracameral implant) 75 mcg.

STEP 4 Prescription Information for iDose® TR

Drug: iDose® TR (travoprost intracameral implant) 75 mcg **Quantity:** ☐ 1 kit ☐ 2 kits **Refills:** *None*
Directions: Administer 75mcg iDose® TR implant by intracameral insertion into the affected eye(s) as directed

ICD-10 DIAGNOSIS CODE		RIGHT (1) DOS	LEFT (2) DOS	STAGE CODE
H40.11XX	Primary open-angle glaucoma			
H40.13XX	Pigmentary glaucoma			
H40.14XX	Capsular glaucoma with pseudoexfoliation of lens			
H40.05XX	Ocular hypertension			

Each diagnosis code must include one of the following to indicate which eye is being treated:
1 = right eye 3= bilateral
2= left eye 9 = unspecified eye

Each diagnosis code must include one of the following to indicate the state of the patient's condition:
0 = stage unspecified 1 = mild stage 2 = moderate stage
3 = severe stage 4 = indeterminate stage

☐ I am currently enrolled with GPS and by checking this box I wish to facilitate treatment of this patient by requesting that Orsini Specialty Pharmacy 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, 0660T, Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach.

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 GPS 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: _____

PM-US-1921 V-2