Copay Assistance Patient Enrollment Form

For support: 1-844-MyiDose/844-694-3673 | Monday–Friday, 8:00 AM–8:00 PM ET

(Pages 1-2 to be completed by the patient; page 3 to be completed by the provider, if applicable)

iDose® TR (travoprost intracameral implant) 75 mcg

Submission Instructions

Please submit a copy of the front and back of your insurance card(s) with this form.

Fax your copay assistance enrollment form to **1-844-iDosefx/844-436-7339.**

Complete all sections of this form to apply for iDose® TR copay assistance. All information is required unless marked optional. Enrollment does not require that treatment has already occurred. Copay reimbursement claims must be submitted within 180 days of the date of service.

Patient Information

First Name: | Middle Initial (Optional): | Last Name:

Date of Birth (MM/DD/YY): | Gender: ☐ F ☐ M ☐ U

Address (Street, Apt/Suite):

City: | State: | Zip Code:

Phone: | Email:

Prescriber Information

First Name: | Last Name:

Address (Street, Apt/Suite):

City: | State: | Zip Code:

Phone: | Email: | Prescriber NPI Number:

Practice Name: | Practice NPI Number:

Site of Care/Treatment Location Name (if different from Practice Name): | Site of Care NPI Number:

Copay Payment Status

Complete if you have received treatment; otherwise, leave blank.

Have you paid the copay out-of-pocket? ☐ Y ☐ N

If Yes, and you are seeking reimbursement directly, proof of payment is required along with the Explanation of Benefits (EOB).

If No, reimbursement may be issued directly to your healthcare provider; their certification on page 3 will be required.

Copay Assistance Eligibility

Is the patient a resident of the United States or U.S. territories? ☐ Y ☐ N

Is the patient enrolled in a Medicare prescription coverage plan? ☐ Y ☐ N

Does the patient have prescription drug insurance coverage? ☐ Y ☐ N

Does the patient have prescription drug coverage through a Medicare prescription plan, Medicaid, Medigap, VA, DoD or Tricare, or other federal or state healthcare programs, including any state prescription drug assistance? ☐ Y ☐ N

Date of Service (if applicable):

ICD Code/Diagnosis Description:

Insurance Information Optional if attaching front and back of insurance card(s)

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other ☐ Uninsured

Primary Insurance Name:	**Secondary Insurance Name:**
Policy ID #:	Policy ID #:
Group #:	Group #:
Policyholder First and Last Name:	Policyholder First and Last Name:
Insurance Phone:	Insurance Phone:
Policyholder Date of Birth:	Policyholder Date of Birth:

Copay Assistance Program Terms and Conditions

- Patient eligibility requires enrollment in iDoseCareConnect™ and completion of a benefits investigation.
- The iDose® TR Copay Program ("Program") is available exclusively to patients with commercial (private or non-governmental) insurance who have a valid prescription for an FDA-approved use of iDose® TR.
- Patients who use Medicare, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD), TRICARE, or any other federal or state government program (collectively, "Government Programs") to pay for iDose® TR or related administration services are not eligible.
- The Program is also invalid if all costs can be fully reimbursed by commercial insurance or other assistance programs.
- Under the Program, patients may still be required to pay a co-pay. Depending on individual insurance coverage, out-of-pocket expenses for iDose® TR may be reduced to as little as $0 per calendar year. The exact out-of-pocket cost depends on the patient's health insurance plan.
- The Program helps cover the cost of iDose® TR and, where allowed by law, may also assist with eligible procedure costs directly related to its administration. Program benefits cannot exceed the patient's actual out-of-pocket expenses for iDose® TR. This Program is not health insurance or a benefit plan; the patient's non-governmental insurance remains the primary payer.
- Once enrolled, the Program will honor claims for services rendered up to 180 days prior to the enrollment date. Claims must be submitted within 180 days of the date of service, unless otherwise specified.
- Use of this Program must comply with all relevant health insurance requirements. Patients, pharmacies, physicians' offices, and hospitals participating in the Program are responsible for reporting all Program benefits received, as required by insurers or the law.
- Program benefits may not be sold, purchased, traded, or offered for sale.
- The patient or their guardian must be at least 18 years old to receive assistance through the Program. The Program is valid only in the United States and U.S. Territories and is void where prohibited by law.
- The Program's value is intended solely for the benefit of the patient. Funds provided through the Program may only be used to reduce out-of-pocket costs for enrolled patients.
- Patients must have commercial insurance and provide proof of financial responsibility for a portion of the drug and/or procedure cost, if applicable.
- This offer cannot be combined with any other rebate, coupon, or similar offer for iDose® TR.
- Glaukos reserves the right at any time to delete, modify, or change the terms, benefits, and conditions without notice.

Patient/Caregiver Certification

By signing below, I agree to the Terms and Conditions of the Program. I further certify that for the patient identified above neither iDose® TR nor the related procedure are paid for or covered, in whole or in part, by any Government Programs. I further certify that the information provided in this document is, to the best of my knowledge, accurate and complete.

Patient/Caregiver Name: | Patient/Caregiver Signature: | Date:

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To be completed by patient or patient representative

Permission to Release Personal Information: REQUIRED

By signing below, I authorize my healthcare providers, pharmacies, and health insurers to use and to share with Glaukos, Corp., iDoseCareConnect, and their representatives, agents, and contractors, including Orsini Specialty Pharmacy, Inc. and IQVIA (collectively "Program"), 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 Program 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 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 Program as described above, it may not remain protected by federal privacy law, including the Health Insurance Portability 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 iDose® TR financial and patient assistance programs. I also understand that I may cancel this authorization at any time by calling 1-855-537-4692 and requesting such cancellation, but that any such cancellation will not affect the sharing of my PHI before my cancellation. I understand that I have the right to receive a copy of this authorization when it is signed.

Glaukos Promotional Communications: Optional

☐ By checking this box, I consent to receive Glaukos promotional communications, including via text, email, phone & voicemails, including with automated telephone dialing technology or pre-recorded messages regarding news, products, events, programs, or clinical trials. Message and data rates may apply. I know that I am not required to consent to receiving promotional communications to receive goods or services. I can contact Glaukos at any time to opt-out or reply STOP to stop text messaging.

For more information visit www.Glaukos.com

Patient First Name: _____ Patient Last Name: _____

Patient Signature: _____ Date: _____

Legally Authorized Representative (Required if under 18)**:**

Representative First Name: _____ Representative Last Name: _____

Representative Relationship to Patient: _____

Representative Signature: _____ Date: _____

INDICATION AND IMPORTANT SAFETY INFORMATION

Indications and Usage

iDose TR (travoprost intracameral implant) is indicated for the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OHT).

IMPORTANT SAFETY INFORMATION

Dosage and Administration

For ophthalmic intracameral administration. The intracameral administration should be carried out under standard aseptic conditions.

Contraindications

iDose TR is contraindicated in patients with active or suspected ocular or periocular infections, patients with corneal endothelial cell dystrophy (e.g., Fuch's Dystrophy, corneal guttatae), patients with prior corneal transplantation, or endothelial cell transplants (e.g., Descemet's Stripping Automated Endothelial Keratoplasty [DSAEK]), patients with hypersensitivity to travoprost or to any other components of the product.

Warnings and Precautions

iDose TR should be used with caution in patients with narrow angles or other angle abnormalities. Monitor patients routinely to confirm the location of the iDose TR at the site of administration. Increased pigmentation of the iris can occur. Iris pigmentation is likely to be permanent.

Adverse Reactions

In controlled studies, the most common ocular adverse reactions reported in 2% to 6% of patients were increases in intraocular pressure, iritis, dry eye, visual field defects, eye pain, ocular hyperaemia, and reduced visual acuity.

Please see full Prescribing Information.

You are encouraged to report all side effects to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088. You may also call Glaukos at 1-888-404-1644.

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Provider: Complete this section if direct reimbursement is needed.

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Healthcare Provider Certification and Signature

By signing this Certification for the Copay Assistance Enrollment Form, I attest that for the patient referenced herein neither iDose® TR nor the related procedure are paid for, in whole or in part, by any Government Programs, and that any level of coverage—even if the patient chooses to self-pay—means the patient is not eligible for this program. I further attest that all eligibility requirements described in the Terms and Conditions are satisfied. I understand that I must report any benefits I receive through this program, as required by insurers, payors, or otherwise under applicable laws, and that any fraudulent or unlawful use of the Program is strictly prohibited and may result in termination of benefits and potential legal liability.

The Program's value is intended solely for the benefit of the patient. Funds provided through the Program may only be used to reduce out-of-pocket costs for enrolled patients. Patients must have commercial insurance and provide proof of financial responsibility for a portion of the drug and/or procedure cost, if applicable. This offer cannot be combined with any other rebate, coupon, or similar offer for iDose® TR. Glaukos reserves the right at any time to delete, modify, or change the terms, benefits, and conditions without notice.

By signing below, I agree that Glaukos Corp., along with its affiliates, agents, representatives, collaborators, and service providers, may use my information and the information of the practice with which I am affiliated for the purposes stated herein. My signature certifies that the individual named on this form is my patient; that the information provided in this application is, to the best of my knowledge, complete and accurate; and that treatment with iDose® TR is medically necessary.

Provider First Name: _____ Provider Last Name: _____ Provider NPI: _____

Practice Name: _____ Group NPI: _____ Office Contact: _____

Practice Address: _____ Practice City: _____ Practice State: _____ Practice Zip Code: _____

Office Phone Number: _____ Office Fax: _____ Office Email: _____

*ICD-10 Diagnosis Code

	Right Eye (OD)	Left Eye (OS)
Primary Diagnosis	☐ H40.05XX Ocular hypertension ☐ H40.10XX Unspecified ☐ H40.11XX Primary open-angle glaucoma ☐ H40.13XX Pigmentary glaucoma ☐ H40.14XX Capsular glaucoma with pseudoexfoliation of lens ☐ Other: _____ **Stage:** _____	☐ H40.05XX Ocular hypertension ☐ H40.10XX Unspecified ☐ H40.11XX Primary open-angle glaucoma ☐ H40.13XX Pigmentary glaucoma ☐ H40.14XX Capsular glaucoma with pseudoexfoliation of lens ☐ Other: _____ **Stage:** _____

**After selecting a diagnosis, enter the appropriate seventh character to indicate stage: 0=Unspecified 1=Mild 2=Moderate 3=Severe 4=Indeterminate*

Site of Care/Treatment Location (if different from Practice Name)

Site of Care Name: _____ Site of Care NPI Number: _____

Site of Care Phone Number: _____ Site of Care Fax: _____

Preferred Method of Communication: ☐ Phone ☐ Fax ☐ Email

Prescriber Signature: _____ Date: _____

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