Enrollment Form for JETREA® (ocriplasmin) and Patient Assistance

To initiate the patient benefit verification process, please complete and submit this enrollment form by fax to **1-855-362-0729**, by e-mail to jetreainfo@thrombogenics.com, or mail to: ATTN: JETREA CARE®, 2730 S. Edmonds Ln, Suite 300, Lewisville, TX 75067. Your patient may also choose to investigate eligibility for the patient assistance programs by completing this form (please see page 2). JETREA CARE® Coordinators can be reached at **1-855-879-5387** to answer general questions Monday through Friday from 7:00 AM to 7:00 PM CST or you can visit our online resource, JETREACARE.com.

A. Patient and Insurance Information (Required)

Patient Medical Record # (required): ______________________ Site of Service: Physician Office Hospital/ASC

Patient's First Name: __________ Middle Initial: ___ Last: ____________ Date of Birth: __________ Sex: M F

Street Address: ______________________ SSN: _____-_____-_______ Primary Language: ______________

City: __________________ State: __________ ZIP: ___________ US/Puerto Rico Resident: Yes No

Primary Phone #: (_____) __________ Secondary Phone #: (_____) __________ E-mail Address: ______________

Primary Insurance Plan: Medicare Commercial/Private Medicaid Other

Policy Holder's Name: ______________________

Policy Holder's Date of Birth: ______________________

Primary Insurance Plan information may be provided by completing the below OR attaching a front/back photocopy of Insurance Plan Card.

Please indicate if attached: Yes No

Insurance Plan Name: ______________________

Phone #: (_____) ______________________

Employer: ______________________

Policy ID #: ____________ Group ID #: ____________

Health Insurance Plan Name: ______________________

Secondary Insurance Plan: Medicare Commercial/Private Medicaid Other

Policy Holder's Name: ______________________

Policy Holder's Date of Birth: ______________________

Secondary Insurance Plan information may be provided by completing the below OR attaching a front/back photocopy of Insurance Plan Card.

Please indicate if attached: Yes No

Insurance Plan Name: ______________________

Phone #: (_____) ______________________

Employer: ______________________

Policy ID #: ____________ Group ID #: ____________

Health Insurance Plan Name: ______________________

B. Information for Diagnosis (ICD-10) (Required)

ICD-10 Code: H43.821 (Right Eye) H43.822 (Left Eye) H43.823 (Bilateral) Diagnosis Date: ________ Treatment Scheduled Date: ________

C. Prescription (R_X)

Product Name: **JETREA (ocriplasmin) Intravitreal Injection, 2.5 mg/mL** Dosage: **0.125 mg**

Prescriber Signature: ______________________________ **Date:** ______________

D. Prescribing Physician Information and Physician Enrollment Certification (Required)

Prescriber Name & Title: ______________________ State License #: ________ Tax ID #: ________

Site/Facility Name: ______________________ Medicaid/Medicare Provider #: ________ NPI #: ________

Street Address: ______________________ City: ______________ State: ________ ZIP: ________

Office Contact Name: ______________________ Office Phone #: (_____) ________ Office Fax #: (_____) ________

Office E-mail Address: ______________________ *Please use **office fax number** and **e-mail** for best receiving results*

I verify the information I have provided in the enrollment form is complete and accurate to the best of my knowledge. I have obtained patient's authorization, as indicated below, to disclose his or her health information related to the treatment with JETREA to ThromboGenics® and its authorized JETREA CARE® agents to use and disclose as necessary in the provision of health services or to offer patient care and support services and/or reimbursement support services.

Prescriber Signature: ______________________ **Date:** ______________________

E. Patient Authorization for JETREA and Patient Assistance Program (Required)

My signature of this JETREA CARE® Patient Assistance Program enrollment form confirms that I authorize each of my prescribing physicians, pharmacists, including any specialty pharmacy, patient assistance program, which receives my prescription for JETREA, and other healthcare providers (together, "Healthcare Providers"), as well as each of my health insurers (together, "Insurers") to use and disclose my protected health information, including, but not limited to, my medical records regarding my treatment with JETREA, my health insurance coverage, my name, address, telephone number, Insurers, and/or group numbers (together, "Health Information") to ThromboGenics and its affiliated companies, vendors, agents, collaboration partners, and representatives (collectively, "ThromboGenics and its agents"), as well as to providers of alternate sources of funding for prescription drug reimbursement for the following purposes: i) enroll me in the JETREA CARE® Patient Assistance Program and contact me (and/or the person legally authorized to sign on my behalf, or the caregiver(s) I have authorized to be contacted on my behalf), if necessary, for enrollment questions, ii) provide me (and/or the person legally authorized to sign on my behalf, or the caregiver(s) I have authorized on my behalf) with educational materials and other support services related to JETREA by mail, e-mail, and/or telephone, iii) verify, investigate, assist with, and coordinate my coverage for JETREA with my Insurers, iv) coordinate prescription fulfillment; v) assist ThromboGenics in obtaining payment from my Insurers; and (vi) provide me with other product information or surveys about my treatment experience with JETREA. I understand that once my Health Information has been disclosed to ThromboGenics and its agents, federal and state privacy laws may no longer protect it. However, ThromboGenics agrees to protect my Health Information by using and disclosing it only for the purposes described in this Authorization or as permitted by law. I understand that signing this Authorization is voluntary and, if I do not sign this Authorization, it will not affect my ability to obtain treatment from my prescribing physician or obtain insurance or insurance benefits. If I refuse to sign this enrollment form, or revoke my authorization later, I understand that this means I will not be able to participate in or receive assistance from the JETREA CARE® Patient Assistance Program. I understand that I may cancel (revoke) this Authorization at any time by mailing a request to 2730 S. Edmonds Ln, Suite 300, Lewisville, TX 75067, or by calling **1-855-879-5387**. I understand that revoking this Authorization will end further uses and disclosures of my Health Information by the parties identified above except to the extent those uses and disclosures have been made in reliance upon this Authorization and as permitted by applicable law. This Authorization expires 3 years from the date indicated below, unless I revoke it earlier. I am entitled to receive a copy of this Authorization.

Patient/Guardian Signature: ______________________________ **Date:** ______________

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Patient Assistance Eligibility and Enrollment Application

F. Patient Insurance Status (Required)

Please indicate your current insurance coverage (check one box only):

Government insurance (eg Medicare; go to **SECTION G**, then **SECTION K**)

Commercial insurance (go to **SECTION H**, then **SECTION K**)

Commercial insurance but presently uninsured (go to **SECTION I**, then **SECTION K**)

Uninsured (go to **SECTION J**, then **SECTION K**)

G. Patients Insured by Government Programs (ie, Medicare, Medicaid, Fed. Employee BCBS)

Please select if you are interested in having your eligibility reviewed for co-pay assistance.
Please indicate your household adjusted gross income: ______________________________

Medicare co-pay foundations provide assistance regardless of the choice of medicine, and decisions are based on financial need and according to criteria established by individual foundations. ThromboGenics® can assist patients by referring them to these independent organizations. ThromboGenics cannot guarantee that patients will be eligible for or receive assistance after referral. ThromboGenics does not have controlling or managerial influence on these independent organizations.

H. Patients Insured by Commercial Insurance Plans

Please select if you are interested in the JETREA CARE® CO-PAY ASSISTANCE PROGRAM, which supports eligible patients with private commercial insurance by covering any cost combination (co-pay, co-insurance, and/or deductible).

You may be eligible for the JETREA CARE® CO-PAY ASSISTANCE PROGRAM if:

Your annual household adjusted gross income is $150,000 or less: Yes No

Please indicate your household adjusted gross income: ________________ Number of household members: _________

______ initials **Patient Attestation:** I agree that, if requested, I will provide proof of income or other eligibility requirement in a timely manner.

______ initials **Physician Attestation:** By participating in the program, I agree that I will not submit any third-party claims for patient cost-sharing expenses covered by the program. I agree that I will disclose my participation in the program to third-party payers. I also certify that my program participation is consistent with my obligations as a participating provider with any third-party payers.

I. Uninsured Commercial Patients

You may be eligible for the patient assistance program if you have no health insurance, including if you do not have drug coverage due to a drug benefit carve-out, or are rendered uninsured due to a payer claim denial.

Your annual household adjusted gross income is $100,000 or less: Yes No
Income documentation is attached* (1040, 1040EZ, IRS-W2, SSI Letter, SSDI, or Letter of Income): Yes No

*Income documentation and residency verification will be required for this program.

J. Uninsured Patients Applying to Receive JETREA® (ocriplasmin) Free of Charge

______ initials **Patient Attestation:** I would like to receive JETREA at no charge under the JETREA CARE® underinsured patient program. I certify that I do not have prescription drug coverage under Medicare, Medicaid, or a public or private insurance plan, or that I have been deemed to be uninsured. I understand that ThromboGenics has the right to modify or discontinue the program at any time; to audit reported income, insurance information, and medical records; and to contact me to confirm receipt of JETREA.

______ initials **Physician Attestation:** I acknowledge that JETREA will not be offered for sale, and no claim for reimbursement of either JETREA or related procedures and services will be submitted to Medicare, Medicaid, or any third-party payer. I understand that ThromboGenics has the right to contact my patient to confirm receipt of JETREA, and to modify or discontinue the program at any time.

K. Patient and Physician Acknowledgement (Required)

By signing this form, I acknowledge that all information provided is complete and accurate to the best of my knowledge. I understand that ThromboGenics will use this information to determine my eligibility for patient assistance, and may provide it to the independent foundations managing the patient assistance programs pursuant to my authorization for use/disclosure of health information.

Patient Signature: ____ Date: __________________

Patient's Full Name (please print): ________________________________ Date of Birth: ____________

By signing this form, I certify that the person named on this form is my patient, the information provided is complete and accurate, and the JETREA received in response to this application is only for the approved indicated use of JETREA for the patient named on this form.

Prescriber Signature: ____ Date: _________________________

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