MAIL THIS TO YOUR INSURANCE PROVIDER

LETTER TO HEALTH PLAN

VEVYE® (Cyclosporine ophthalmic solution) 0.1%

To whom it may concern:

I am an enrollee in your prescription drug plan, and this letter is to advise you that I have been prescribed VEVYE® (Cyclosporine ophthalmic solution) 0.1% by my physician. I am purchasing this product outside of my insurance benefit with the VEVYE® and PhilRx Program sponsored by Harrow, Inc.

This letter is not a request for reimbursement, as I have agreed to not seek reimbursement for my purchase in accordance with the Terms and Conditions of the VEVYE® and PhilRx Program.I am an enrollee in Medicare Part D or a Medicare Advantage prescription drug plan. I also have agreed that I will not count my purchases toward my true out-of-pocket expenses (TrOOP), and I will continue to use the VEVYE® and PhilRx Program for as long as I take the medication during the calendar year.

If you have questions about the medication or the VEVYE® and PhilRx Program, please contact PhilRx at [1-855-977-0975].

Sincerely,

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NAME	DATE	DATE OF BIRTH

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PRESCRIPTION PLAN	PRESCRIPTION PLAN MEMBERSHIP ID NUMBER