Verkazia®
cyclosporine ophthalmic emulsion 0.1%

Verkazia Patient Assistance Program
Patient Enrollment Form

Fax the Patient Enrollment Form to Scripts Rx's fax number: (877) 991-1798

Patient Information

Name:_____ Date of Birth *(MM/DD/YYYY)*:_____

Cell Phone:(_)_____ Email:_____

Shipping Address:_____ City:_____ State:_____ ZIP:_____

Sex: ☐ Male ☐ Female

Primary Language:_____

Strength/Form	Quantity	Supply	Day Supply	Refills	Dosage/Administration
Verkazia (cyclosporine ophthalmic emulsion) 0.1%	120 single dose vials of 0.3mL each	120 single dose vials	30		Instill 1 drop of Verkazia, 4 times daily (morning, noon, afternoon, and evening) in each affected eye.

ICD-10 or Diagnosis: _____

Prior Medication Trials/Failures *(treatment name, duration, and reason for discontinuation):*

Has the patient started treatment 1. Yes. 2. No

Anticipated start date of treatment:_____

Prescriber Information

Name:_____ NPI #:_____

Address:_____ City:_____ State:_____

ZIP:_____ Office Contact Name: _____ Phone:(_____)_____

Fax:(_____)_____ *(for prescription status updates)*

Office Information

Address:_____ City:_____ State:_____

ZIP:_____ Office Contact Name: _____ Phone:(_____)_____

Fax: (_____)_____ *(for prescription status updates)*

Physician Certification

My signature below certifies that the person named on this form is my patient, the information provided on this application is complete and accurate, and that VERKAZIA® received in response to this application is only for the use of VERKAZIA for the patient named on this form. With regard to any patient eligible for patient assistance through the VERKAZIA Patient Assistance Program, I acknowledge that this medication will not be offered for sale, trade, or barter and EITHER no claim for reimbursement of either VERKAZIA or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer OR I will provide appropriate denial and appeals documentation to support requests for patients who are deemed uninsured after a claim was submitted. I consent to Harrow and its representatives and contractors contacting me by fax, phone, mail, or email to confirm receipt of VERKAZIA or provide additional information about VERKAZIA or The VERKAZIA Patient Assistance Program and that Harrow may revise, change, or terminate any program services at any time without notice to me. I authorize Harrow and its representatives and contractors to forward this prescription to a dispensing pharmacy on behalf of myself and my patient, and I appoint The VERKAZIA Patient Assistance Program solely to convey the prescription herein on my behalf to the pharmacy chosen by or for the above-named patient.

Physician Signature: _____ ***Date:*** _____

Please complete this application and submit by fax to ScriptsRx's fax number **(877) 991-1798**

Insurance Information

Check the box that applies:

☐ Commercial/Private ☐ Medicare ☐ Part D ☐ Medicaid ☐ Other Uninsured

Authorization to Disclose/Use Health information (Section1.1)

I authorize my health care providers, my health insurer, health plan or programs that provide me health care benefits and any specialty pharmacies to disclose to Harrow and its representatives and contractors the information on this enrollment application and any other information related to my treatment with VERKAZIA.

My health care providers, health insurers, specialty pharmacy and Harrow may use and disclose my information for the following purposes:

- ***To determine if I am eligible to participate in Harrow's reimbursement assistance program, patient assistance program and other support programs (together "VERKAZIA Patient Assistance Program").***
- ***For the operation and administration of the VERKAZIA Patient Assistance Program.***
- ***To investigate my health insurance coverage benefits.***
- ***To obtain prior authorizations for reimbursement.***
- ***To assist with appeals of denied claims for reimbursement; and***
- ***To refer me to, or to determine my eligibility for, other programs, foundations or alternate sources of funding or coverage that may be available to provide assistance to me with the costs of my medications****.*

I understand that, once my information has been disclosed to Harrow, federal privacy laws may no longer protect it. However, Harrow agrees to protect my information by using and disclosing it only for the purposes authorized in this authorization or as required by law. I understand that if I refuse to sign this authorization, I will not be able to participate in the VERKAZIA Patient Assistance Program, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance coverage. Further, I understand that I may withdraw (take back) this authorization at any time by mailing or a written request to (Market Access Department, Harrow at P.O. Box, 102 Woodmont Blvd, Nashville, TN 37205)

This authorization expires 18 months from the date support is last provided under The VERKAZIA Patient Assistance Program unless I withdraw it earlier. I understand that I will receive a copy of this authorization.

Patient Signature: _____ ***Date:*** _____

Financial Information (must be completed for co-pay assistance and patient assistance requests) (Section1.2)

Total Household Income (including salary/wages; Social Security income; disability income; any other income)*

- ☐ $0 to $25,000
- ☐ $25,001 to $50,000
- ☐ $50,001 to $75,000
- ☐ $75,001 to $100,000
- ☐ Greater than $100,000

*Patient Certification (supporting documentation required) (Section1.3)

By signing below, I verify that the information on this application and other supporting documentation is complete and accurate. I also verify that unless I have identified otherwise in this application, I have no other coverage for prescription medications, including Medicaid, Medicare, or any public or private assistance programs, or any other form of insurance. I also agree that Harrow may verify my eligibility for the VERKAZIA Patient Assistance Program, and I understand that such verification may include contacting me or my health care provider for additional information and/or reviewing additional financial, insurance, and/or medical information. In connection with administering The VERKAZIA Patient Assistance Program, I understand that Harrow may contact me or my health care provider directly to confirm receipt of medications or to provide other information related to The VERKAZIA Patient Assistance Program. I also understand that Harrow may revise, change, or terminate The VERKAZIA Patient Assistance Program at any time.

Patient Signature: _____ ***Date:*** _____

Physician Patient Signature Certification

My signature below certifies the following: (i) that the person named on this Enrollment Form is my patient, (ii) that I have obtained his/her written authorization and certification under Sections 1.1 and 1.3 of this form, (iii) that I will retain in my files the complete patient-executed Enrollment Form, and (iv) that upon request, I will promptly provide a copy of this patient-executed Enrollment Form on file to VERKAZIA Patient Assistance Program.

Physician Signature: _____ ***Date:*** _____

Please complete this application and submit by fax to (877) 991-1798

Have questions or need assistance?

Call **1-316-219-4495** to speak with a Support representative.

HARROW™

Your patients. Our purpose.