Enrollment Form For JETREA® (ocriplasmin) And Patient Assistance

To initiate patient benefit verification process please complete and submit enrollment form by fax (855-362-0729), online at JETREACARE.com, or mail to: ATTN: JETREA CARE, 6900 Dallas Parkway, Suite 200, Plano, TX 75024. 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 **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

Office Portal Registration (please complete section D and submit via Fax or RBM)

A. Patient And Insurance Information (Required)

Patient Medical Record #: ______ 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-9) (Required)

ICD-9 Code: 379.27 Affected Eye: Right Eye Left Eye Diagnosis Date: ______

C. Prescription (R_X)

Product Name: **JETREA® (ocriplasmin) Intravitreal Injection, 2.5 mg/mL** Dosage: **0.125 mg**
Preferred Specialty Pharmacy: ______
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 **email** 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 your 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 Use/Disclosure Of Health Information (Required)

I authorize my prescribing physician and any health insurers, plans, or programs that provide me health care benefits (collectively, "Health Plans") to disclose my medical or other information, including information about my treatment with JETREA, ThromboGenics and its authorized JETREA CARE agents so that ThromboGenics may use and disclose the Information for the following specific purposes: ordering, manufacturing, delivering, and injection of JETREA. ThromboGenics obtaining payment from my Health Plan(s); conducting reimbursement verification; applying for or making referrals for Co-pay Assistance upon request; and providing me with educational and treatment support services by mail, e-mail, and/or telephone. I understand that, once my Information has been disclosed to ThromboGenics, federal and state privacy laws may no longer protect it. However, ThromboGenics agrees to protect my information by using it only for the purposes authorized in this Authorization or as permitted by law. I understand that signing this Authorization is voluntary and, if I do not sign the Authorization, it will not affect my ability to obtain treatment from my prescribing physician or obtain insurance or insurance benefits. I understand, however, that if I do not sign this Authorization, I will not be eligible to receive services and Co-pay Assistance. I may withdraw this Authorization at any time by faxing a written request to JETREA CARE at **855-362-0729** or by mailing to JETREA CARE, 6900 Dallas Parkway, Suite 200 Plan, TX 75024. Withdrawal of this Authorization will end further uses and disclosures of my Information by the parties identified in this Authorization, 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 10 years from the date indicated below unless I withdraw it earlier. I am entitled to receive a copy of this Authorization.

Patient/Guardian Signature: ______ **Date:** ______

Please fax completed enrollment form to JETREA CARE (855-362-0729); mail to ATTN: JETREA CARE, 6900 Dallas Parkway, Suite 200, Plano, TX 75024.

JETREA™ (ocriplasmin) Intravitreal Injection, 2.5 mg/mL
CARE

Patient Assistance Eligibility And Enrollment Application

F. Patients Insured Through Government Programs (Eg, Medicare)

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.

G. Patients Insured Through Commercial Insurance Plans (Signatures Required)

Please select if you are interested in the JETREA® CARE Co-pay Program. JETREA CARE supports eligible patients with private commercial (non-government payers) insurance by covering any combination of cost (co-pay, co-insurance, and/or deductible).

You may be eligible for the JETREA CARE Co-pay Program if:
Your annual household adjusted gross income is $100,000 or less: Yes No
Please indicate your household adjusted gross income: ______________________________ Number of household members: _________

Patient Attestation: I verify that the information that I have provided to enroll in the JETREA CARE Co-pay Program is complete and accurate to the best of my knowledge. I agree that, if I am requested, I will provide proof of income or any other eligibility requirement in a timely manner.

Patient Signature: ____ Date: ______________________

Physician Attestation: By participating in the program, I agree that I will not submit any third-party claims for patient cost-sharing expenses (including co-pay, deductibles, and/or co-insurance) that are covered by the JETREA CARE Co-pay Program. I also agree that I will disclose my participation in the Co-pay Program to third-party payers as required. In addition, I certify that my participation in this program is consistent with my obligations as a participating provider with any third-party payers.

Prescriber Signature: ____ Date: ______________________

H. Uninsured 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.

I. Patient And Physician Certification (Only Required If Patient Is Uninsured At The Time Of Enrollment And Is Applying To Receive JETREA® (ocriplasmin) Free Of Charge)

I would like to receive JETREA at no charge under the JETREA CARE underinsured patient program. I understand that all the information I provide in connection with this application will be used to determine my eligibility to participate in the program. I certify that I do not have coverage for prescription drugs under Medicare, Medicaid, or other public or private insurance plan, or that it has been determined that I am functionally uninsured. I understand that ThromboGenics, the manufacturer of JETREA, reserves the right to modify the eligibility requirements or discontinue the program at any time. I hereby certify the accuracy of the information submitted on, and in connection with, this application. I acknowledge that ThromboGenics has the right pursuant to my authorization for use/disclosure of health information to verify my eligibility for the JETREA CARE patient assistance program, to audit reported financial income and insurance information and medical records, and to contact me directly to confirm receipt of JETREA.

Patient Signature: ____ Date: ______________________

My signature below certifies that the person named on this form is my patient, the information provided on the application 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. I acknowledge that this medication will not be offered for sale, and no claim for reimbursement of either JETREA or related medical procedures and services will be submitted to Medicare, Medicaid, or any third-party payer. I understand that ThromboGenics and JETREA CARE agents have the right to contact my patient directly to confirm receipt of JETREA and that ThromboGenics may revise, change, or terminate this program at any time.

Prescriber Signature: ____ Date: ______________________

J. Patient Acknowledgement (Required For All Programs)

By signing this form, I acknowledge that all eligibility information provided is accurate to the best of my knowledge. I acknowledge that by indicating I am interested in any patient assistance program described above, ThromboGenics may provide the information included on this form to the independent foundations that manage 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: _______________

Please fax completed enrollment form to JETREA CARE (855-362-0729); mail to ATTN: JETREA CARE, 6900 Dallas Parkway, Suite 200, Plano, TX 75024.

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