Verkazia® Enrollment Form

Fax completed form to Verkazia® Patient Support at: 1-833-577-2866
Phone: 1-833-577-7277 or visit: santenpass.com/verkazia

SECTION 1: PATIENT INFORMATION

Patient name: (First, Middle, Last)	Suffix:	Sex:	Patient date of birth:	Patient email:	
Address:	City:	State:	Zip:	Phone:	Mobile:
Parent/guardian name: (First, Middle, Last)	Parent/guardian phone:			Parent/guardian email:	
Preferred method of communication: Mobile Phone Text Email	Patient preferred language:			Best time to contact: AM PM	

SECTION 2: PATIENT INSURANCE *Complete the fields below and/or provide copies of the insurance card(s)*

Does patient have insurance? Yes No	Patient pharmacy:		Does patient have prescription insurance? Yes No
Health plan insurer:	RX plan:	Member ID:	RX member ID:
Health plan phone number:	RX plan phone number:	Cardholder name:	Cardholder date of birth:
Relationship to cardholder: Self Spouse Child Other (Please list)			

SECTION 3: PRESCRIBER INFORMATION

Prescriber name: (First, Last)	NPI	Medicaid ID:	State license:
Specialty: Ophthalmology Other (Please Specify)		Practice name:	
Practice address:			City:
State:	Zip:	Phone:	Fax:
Email:	Office contact name:	Preferred method of communication:	

SECTION 4: MEDICAL AND PRESCRIPTION INFORMATION

Allergies:		Concurrent medications:	
Verkazia®	Directions:	Quantity:	Refills:

I certify that this therapy is medically necessary, and this information is accurate to the best of my knowledge. I certify that I am the physician that has prescribed Verkazia® to the previously identified patient. I authorize PharmaCord® on behalf of my patient to facilitate processes to assist the patient in obtaining Verkazia® as indicated on this prescription.
The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.
For purposes of transmitting these prescriptions, I authorize Santen Incorporated, its affiliates, business partners, and agents to forward as my agent for these limited purposes these prescriptions electronically, by facsimile, or by mail to the appropriate dispensing pharmacies.

Dispense as Written Prescriber Signature: ✗ ______________________ **Date:** __________

Substitution Permitted Prescriber Signature: ✗ ______________________ **Date:** __________

Verkazia®
cyclosporine ophthalmic emulsion 0.1%

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Patient Name: (First, Middle, Last)	Patient Date of Birth:

PATIENT HIPAA AUTHORIZATION FOR VERKAZIA® PATIENT SUPPORT SERVICES

I hereby authorize my healthcare providers, my health insurance company, and my pharmacy to disclose my protected health information (PHI) including, but not limited to, my name, address, telephone number, medical records, health insurance coverage, and financial information to Santen Incorporated and companies working with Santen Incorporated (collectively "Santen Incorporated") and its agents for the following purposes:

- Contact me, or the person legally authorized to sign on my behalf, by phone or mail for Verkazia® Patient Support purposes
- I authorize calls/texts may mention the name of Santen products or services, details about my insurance coverage and my doctor's name. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of Santen products or enrollment. Message and data rates may apply. I understand that I may opt out of receiving these communications at any time by calling the Verkazia® Patient Support Program
- Contact my insurance company on my behalf to verify my coverage for Verkazia 1 mg/mL eye drops
- Determine my eligibility, and enroll in the Commercial Copay/Coinsurance Assistance Program
- Determine my eligibility, and enroll in the Patient Assistance Program (PAP), including verification of my financial information
- Coordinate my treatment with my healthcare provider and specialty pharmacy
- Send me educational materials or other program information that may be of interest to me
- Send reminders about refilling medication for adherence support

I understand that Santen Incorporated may offer an ongoing customized patient support program. The support program could include a care coordinator contacting me by telephone, email, or text to provide ongoing personalized support over a period of time.

Once my health information has been disclosed to Santen Incorporated, I understand that federal privacy laws may no longer protect the information. However, I understand that Santen Incorporated and other companies authorized to receive my health information pursuant to this authorization agree to protect my health information by using and disclosing it only for purposes authorized in this authorization or as required by law or regulations. I understand that this authorization does not affect treatment from my healthcare provider or coverage for Verkazia 1 mg/mL eye drops through my insurance.

I understand that this authorization is voluntary. However, if I refuse to sign, or cancel my authorization, Santen Incorporated may not be able to determine my eligibility for the Commercial Copay/Coinsurance Assistance Program or the Patient Assistance Program (PAP). I may cancel this authorization at any time by mailing a letter to PO Box 5490, Louisville, KY 40255. This authorization expires five [5] years from the day that I sign it as indicated by the date next to my signature, unless (i) otherwise canceled as set forth above, (ii) the patient reaches the age of majority, or unless (iii) a shorter period is mandated by the law of my state of residence. I understand that canceling this authorization is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that my pharmacy, health insurers, and third-party vendors may receive remuneration (payment) from Santen Incorporated in exchange for disclosing my personal information to Santen Incorporated and/or for providing me with support services for the purposes described above.

I understand and have read this authorization. I understand that I am entitled to receive a signed copy of this form and can do so by calling the Verkazia® Patient Support Program at 833-577-7277 or by mailing a request to the address above.

✕ ______________________________ ______________________
Print patient or patient representative name **Relationship to patient**

✕ ______________________________ ______________________
Signature of patient or patient representative **Date**