

Instructions for enrolling in the Equal Access Patient Assistance Program

For the Patient

- 1 Complete all relevant fields on the Patient Enrollment Form (reverse side of this page)
- 2 Sign the Patient Certification (reverse side of this page)

For the Facility

- 3 Complete all relevant fields on the Patient Enrollment Form and sign the Physician Certification (reverse side of this page)
- 4 Fax completed form with legible copies of each applicable insurance card, front and back, to **1-855-664-3741**
- 5 Form must be completed and approved 5 days before surgery

If your patient meets the eligibility criteria for the Equal Access Patient Assistance Program, OMIDRIA[®] (phenylephrine and ketorolac intraocular solution) 1% / 0.3% will be provided at no cost for use during your patient's surgery.

FOR PERSONALIZED HELP, CALL THE LIVE ASSISTANCE REIMBURSEMENT HOTLINE AT **1-877-OMIDRIA (1-877-664-3742)**, 9AM-5PM ET, MONDAY-FRIDAY



OMIDRIA[®]

(phenylephrine and ketorolac
intraocular solution)
1% / 0.3%

Patient Enrollment Form

The top section of the form (above the line) should be completed and signed by the patient or patient's legal representative. The bottom section of the form (below the line) should be completed and signed by the physician prior to surgery. A printout of the patient's electronic medical record may be substituted for relevant sections of this form.

PATIENT INFORMATION (Note: only US residents are eligible)

First Name Last Name
Date of Birth Address (not PO box)
City State Zip Code

FINANCIAL INFORMATION (used to evaluate request for patient assistance)

Total Number of People in Household (including Patient)
Total Yearly Household Income (including salary/wages;
Social Security income; disability income; any other income)*

*Supporting documentation may be requested.

PATIENT CERTIFICATION

By signing below I certify that the information I have provided on this application and any supporting documentation that I may provide are complete and accurate, and I authorize my physician to release to OMIDRIAssure® any information necessary to evaluate my eligibility for the Equal Access Patient Assistance Program. I agree that OMIDRIAssure representatives may review and verify my eligibility for the Equal Access Patient Assistance Program and that they may contact me or my physician for additional information. I also agree that, if requested, I will provide proof of my stated income or any other eligibility requirement in a timely manner. I understand that Rayner Surgical Inc. may change or terminate OMIDRIAssure and/or the Equal Access Patient Assistance Program at any time.

Signature of Patient or Patient's Legal Representative
Printed Name Date
Relationship to Patient (if Patient's Legal Representative)

This section of the form should be completed by the physician.

PATIENT INSURANCE INFORMATION

Does the patient have medical and/or prescription benefits through any private commercial or government health insurance program? (If yes, please provide a legible copy of each applicable insurance card.) Yes No

PHYSICIAN INFORMATION

Physician Name NPI No./DEA No.
Patient Diagnosis ICD-9/ICD-10 Code(s)
Procedure Code CPT Code Date of Surgery
Facility/Practice Name
Address (not PO box) City
State Zip Code Phone Fax
Site Contact Name

PHYSICIAN CERTIFICATION

My signature below certifies that the patient named above is my patient and that the information provided is, to the best of my knowledge, complete and accurate. I have obtained the patient's authorization to disclose his or her personal and health information to the OMIDRIAssure program to use and to disclose as necessary in connection with the possible provision of patient and/or reimbursement support services. If the patient is uninsured or insured by a government insurance program and is eligible for the Equal Access Patient Assistance Program, I agree that OMIDRIAssure, provided at no cost, will be used only for the patient named on this form and will not be offered for sale, trade, or barter and that no claim for reimbursement of OMIDRIAssure will be submitted to Medicare, Medicaid, or any other third-party payer. I consent to Rayner Surgical Inc. representatives and agents contacting me to confirm receipt of OMIDRIAssure or to provide additional information about OMIDRIAssure and the OMIDRIAssure program. I agree that Rayner Surgical Inc. may change or terminate any of the OMIDRIAssure program services at any time without notice.

Signature of Physician Date

Dispense: OMIDRIAssure 4-mL vial	Qty 1	Sig: Dilute 4 mL of OMIDRIAssure in 500 mL of ophthalmic irrigation solution. Must be administered by, or under the supervision of, a physician.	Refills: 0
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Fax completed and signed form to 1-855-664-3741

For Indications and Important Safety Information, please read the Full Prescribing Information at www.omidriahcp.com/prescribinginformation.



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OMIDRIA®
(phenylephrine and ketorolac
intraocular solution)
1% / 0.3%