PATIENT ENROLLMENT FORM

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For practices that prefer to fax

1. Complete and sign this Patient Enrollment Form/Prescription
2. Fax Page 1 to Dompé CONNECT to Care at 1-855-263-1775

For practices that prefer or are required to e-prescribe

1. CoAssist Pharmacy (eRx: NCPDP 5733604); Phone: 855-382-2533
   OR: Accredo Specialty Pharmacy (eRx: NCPDP 4436920); Phone: 877-831-8112
2. Note: 1 carton of OXERVATE = 7 mL (1 mL/vial); Full 8 weeks of therapy (8 cartons) = 56 mL per eye

PATIENT INFORMATION

*Denotes required field.

*Full Name: _____ *Date of Birth: _____ Gender: ☐ Male ☐ Female

*Address: _____ *City: _____ *State: _____ *ZIP: _____

*Preferred Phone: _____ Alternative Phone: _____ Patient Email: _____

Preferred Language: _____ Caregiver Contact Name: _____ Caregiver Contact Phone Number: _____

By checking this box, I agree that it is acceptable to leave a message with this caregiver: ☐ Yes

Patient Insurance Information

Please fill out the following information OR attach a copy of the patient's insurance card.

*Primary Insurance Plan (check one): ☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Uninsured

*Policy Holder's Name: _____ *Policy Holder's Date of Birth: _____

*Insurance Plan Name: _____ Phone Number: _____

Employer: _____ Policy Number: _____ Group Number: _____

Prescription Drug Benefit Coverage/Pharmacy Benefit Manager: _____

I have read, understand, and agree with the Patient Information Authorization on pages 2-3.

*Patient/Guardian Signature: _____ *Date: _____

*Patient/Guardian Print Name: _____

PRESCRIBER INFORMATION

*Prescriber Full Name: _____ *NPI Number: _____

*Site/Facility Name: _____ Tax ID #: _____

*Address: _____ *City: _____ *State: _____ *ZIP: _____

*Office Phone: _____ *Office Fax: _____ Office/Account Email: _____

Preferred Method of Communication: _____ Office Contact Name: _____

DIAGNOSIS AND PRESCRIPTION INFORMATION

*ICD-10 Codes Check all that apply to the treated eye(s)	Neurotrophic keratoconjunctivitis	Central corneal ulcer	Unspecified corneal ulcer	Anesthesia and hypoesthesia of cornea	Other	*Stage of Disease:
Right eye	☐ H16.231	☐ H16.011	☐ H16.001	☐ H18.811		
Left eye	☐ H16.232	☐ H16.012	☐ H16.002	☐ H18.812		
Bilateral	☐ H16.233	☐ H16.013	☐ H16.003	☐ H18.813		

*Select one:	Quantity	Day Supply
☐ **Unilateral Treatment**	56 mL	56 days
☐ **Bilateral Treatment**	112 mL	56 days

Product: OXERVATE® (cenegermin-bkbj) ophthalmic solution 0.002%

Directions for Use: Instill 1 drop in the affected eye(s) every 2 hours, 6 times a day, for 8 weeks

No Refills

PRESCRIBER CERTIFICATION AND PRESCRIPTION AUTHORIZATION

I authorize Dompé U.S., Inc., its affiliates, vendors, agents, and contractors (collectively, "Dompé") to act on my behalf for the limited purposes of transmitting this prescription for fulfillment by a designated pharmacy. I represent that I am acting in compliance with HIPAA and that I have a valid authorization from the patient to disclose his or her health information to Dompé in connection with the fulfillment of this prescription, the patient's treatment, and as further detailed in the Voluntary Patient Authorization. I confirm that the information I have provided in this form is complete and accurate to the best of my knowledge. This document and signature authorize the transmission of all necessary information for the prescription to the dispensing pharmacy. I certify I am in compliance with my state-specific prescription requirements such as e-prescribing, state-specific prescription forms, fax language, etc. I understand non-compliance with state-specific requirements could result in outreach to the prescriber.

☐ I'm sending a separate eRx

*Prescriber Signature (No Stamps): _____ *Date: _____

PATIENT INFORMATION AUTHORIZATION (voluntary)

HEALTH INFORMATION CONSENT

As part of our Dompé CONNECT to Care ("DC2C") (the "Services") we collect certain information about your health conditions and diagnoses from you and, with your authorization, your healthcare providers to help us safely provide Services to you. If you choose not to provide this information, we cannot provide our Services. For more information on our data processing practices and rights you may have, please see our Privacy Policy available at https://www.dompe.com/us/privacy-policy/. If you (or your healthcare provider, with your authorization) provide the information and you later change your mind, you may withdraw your consent for future processing or request deletion of your health information at any time by contacting privacy@dompe.com. By signing below, I consent to Dompé U.S. Inc., its affiliates and service providers (collectively "Dompé") collecting and using my health information to provide the Services.

VOLUNTARY PATIENT AUTHORIZATION TO SHARE INFORMATION WITH DOMPÉ

By signing this patient authorization ("Authorization"), I (or the legal guardian or caretaker of such patient on their behalf) hereby authorize my health plans, healthcare providers, healthcare clearinghouses, and their business associates ("Covered Entities," as such term is defined under the Health Insurance Portability and Accountability Act ("HIPAA")) to use and disclose my health information, which may, under some circumstances be considered Protected Health Information ("PHI" as such term is defined under HIPAA) to Dompé (as defined above) including, but not limited to the administrator of the Services (as defined above). Health information that may be transferred to Dompé includes information related to my medical condition(s), treatment, medications, care management, and health insurance, as well as contact and other information provided on this form and any prescription form. This may include information about sexually transmitted infections, HIV status, substance dependencies or treatments if included in my file and relevant to the purposes described in this form.

By and through this Authorization, I authorize Dompé to use my health information for the following purposes:

1. To establish eligibility for the Services. 2. To communicate with Covered Entities and me about my medical care and coverage. 3. To facilitate, assess, support or improve the provision of Dompé products, supplies, or services, including the Services, provided by Dompé or through a third party, including, but not limited to our access hub(s) or specialty pharmacy(ies). 4. To enroll me in patient or product support programs offered by Dompé or other entities for which I may be eligible based on my health information, including but not limited to any OXERVATE® patient support program, and or certain nursing support services, if available. 5. To use and share my information to send me or cause third parties to send me communications and or information regarding my experience with access to and use of OXERVATE and or other Dompé products or services. Such communications may include survey and other market or clinical research invitations, as well as marketing communications. 6. As otherwise required or permitted by law.

I understand and agree that:

1. Dompé contractors or vendors who receive my health information from Dompé for the purposes listed above may also receive direct or indirect remuneration from Dompé in exchange for their communications with me about Dompé patient or product support programs or support services

PATIENT INFORMATION AUTHORIZATION (voluntary), continued

subsidized by Dompé. 2. Any health information disclosed to Dompé by the Covered Entities pursuant to this authorization will no longer be protected by the Covered Entities' HIPAA obligations but will be kept confidential by Dompé subject to its Privacy Policy (located at: dompe.com/us/privacy-policy), and such privacy laws applicable to Dompé. 3. In the event of a business transaction such as the sale or reorganization of all or part of Dompé's business, my health information may be transferred to a purchaser or successor company to permit the above uses to be continued after the business transaction.

I also understand and acknowledge that:

1. I do not need to sign this Authorization in order to receive healthcare treatment or insurance benefits to which I am otherwise entitled, but if I do not sign this Authorization, I will not be able to obtain assistance from DC2C. 2. Upon signature, I may request a copy of the signed Authorization. When filled out electronically, I may download a copy of this Authorization or request that this Authorization be emailed to the email address provided. 3. I may revoke this Authorization at any time in writing by mailing a letter to 1680 Century Center Pkwy, Suite 4, Memphis TN 38134, or by email to: DompeConnect2Care@AssistRx.com. Processing of my request to revoke this Authorization may take up to 30 days from the date of receipt to the physical and or email address indicated above, whichever is received first. 4. A request to revoke this Authorization will apply except to the extent that a Covered Entity has already acted and relied on it, and therefore such revocation will not protect any health information used or disclosed to Dompé by the Covered Entities before the date of receipt and processing of my request to revoke the Authorization. 5. Unless earlier revoked, this Authorization will be valid for three (3) years from the date of my signature below or as otherwise permitted or limited by law. 6. A photocopy or digital copy of this Authorization will have the same force and effect as the original.