

# RETISERT Reimbursement and Patient Assistance Program

Please complete each section to the fullest extent possible. If an item does not apply, please note "N/A" on that line. Return this completed confidential application to:

RETISERT Reimbursement and  
Patient Assistance Program  
PO Box 220827  
Charlotte, NC 28222-0827  
Telephone: 866-250-2974 Fax: (866) 250-2975



## PATIENT INFORMATION

Benefit Verification Request  Patient Assistance Request

Patient Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

For confidentiality purposes, please indicate the number at which you would prefer to be contacted.

Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

If you have no insurance, please indicate "No Insurance" below.

### Primary Insurance

Health Insurance Company: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Contact Person: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Do you have any **secondary insurance**, including **Medicare**?

YES  NO \_\_\_\_\_

Have you applied to **Medicaid** or other public programs

YES  NO If YES, date of application: \_\_\_\_\_

Are you eligible?  YES  NO

If not eligible, reason for denial: \_\_\_\_\_

## FINANCIAL INFORMATION (Patient Assistance only)

Current annual household income \$ \_\_\_\_\_

Do you receive social security income (SSI)?  YES  NO

Number of household members dependent on income stated above (include applicant) \_\_\_\_\_

## APPLICANT DECLARATION (Patient Assistance only)

I verify that the information provided in this application is complete and accurate. I further understand that the RETISERT Patient Assistance Program may request documentation to verify financial or insurance information. *I understand that any assistance in the form of free product is contingent upon my ability to meet the eligibility criteria for the program. I also understand that Bausch & Lomb reserves the right at any time, and without notice, to modify the application form; modify or discontinue this program and its eligibility criteria; or terminate assistance.*

I authorize my healthcare providers to release to the RETISERT Patient Assistance Program (Bausch & Lomb and their agents) medical information necessary to secure or establish health insurance coverage. I authorize the RETISERT Patient Assistance Program to obtain information from my prescribing physician, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of this application. I agree that if I am eligible and receive any free product that I will not submit a claim to seek reimbursement from my health care insurer for such free product

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## PHYSICIAN INFORMATION

Financially needy patients eligible for product assistance will receive free product shipped to the physician's address indicated below. Please attach the patient's prescription to this application.

Physician Name: \_\_\_\_\_

Tax ID # \_\_\_\_\_

State License # \_\_\_\_\_

Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Contact Name \_\_\_\_\_

(e.g. social worker, nurse, or other representative we should contact regarding this patient.)

Address for product shipment, if different from above:

Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

## CLINICAL INFORMATION

For which eye(s) does the patient require RETISERT?

Left Eye  Right Eye  Bilateral

Diagnosis:

- 363.20 Uveitis, posterior
- 136.1 Behçet's disease
- 360.11 Sympathetic uveitis
- 360.12 Panuveitis
- 362.18 Retinal vasculitis
- 363.00 Focal chorioretinitis, unspecified
- 363.10 Disseminated chorioretinitis, unspecified
- 363.12 Disseminated choroiditis and chorioretinitis, peripheral
- 363.13 Disseminated choroiditis and chorioretinitis, general
- 363.20 Chorioretinitis, unspecified (Uveitis, posterior)
- 363.21 Pars planitis
- 363.22 Harada's disease
- 364.24 Vogt-Koyanagi syndrome
- 363.54 Central choroidal atrophy, total
- Other \_\_\_\_\_

Treatment History:

Treatment 1  Treatment 2  Other \_\_\_\_\_

## Statement of Medical Necessity for Financially Needy Patients

To the best of my knowledge, this patient has no medical coverage (including Medicaid or other public programs) for RETISERT.

TRUE  FALSE

I certify that RETISERT is medically indicated for this patient and I will be supervising the patient's treatments.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_