PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Phospholine Iodide® (echothiophate iodide for ophthalmic solution) 0.125%

PRESCRIPTION & ENROLLMENT FORM

__ New patient __ Current patient

How long has the patient been on therapy:_____

PATIENT INFORMATION (Include the front and back copy of the patient's insurance card)

Patient name _____

Date of birth_____ Male Female

Street address _____

City _____State _____ Zip _____

Parent/guardian (if applicable)_____ Principle contact

Home phone _____ Work phone _____

Cell phone _____ Evening phone_____

E-mail address_____

Insurance company name _____

Insurance company phone # _____

Insured name_____

Insured employer_____

Relationship to patient_____

Identification # _____ Policy/group # _____

Prescription card No Yes If yes, carrier_____

Policy # _____ Group # _____

Eligible for Medicare? No Yes Eligible for Medicaid? No Yes

PRESCRIBER INFORMATION

Date_____ Time_____

Prescriber name _____

Prescriber practice title _____

Street address _____

City _____State _____ Zip _____

Phone _____ Fax_____

License # _____ DEA #_____

Physician Medicaid UPIN # _____ NPI# _____

MD specialty _____

Note: This form is intended for prescriber use only.
If faxed, the fax must come from MD office or hospital (should not be faxed by patient).

Phone: 888-347-3416 Fax: 877-231-8302

CLINICAL INFORMATION

ICD-10 code: _____

NKDA Known drug allergies _____

PRESCRIBING INFORMATION

Phospholine Iodide (echothiophate iodide for ophthalmic solution) 0.125%

Quantity _____ Refills _____

Directions_____

Anticipated start date_____ Anticipated duration _____

Deliver product to __ Office __ Patient home Clinic __ Other

Clinic location _____

PHOSPHOLINE IODIDE QUICKSTART PROGRAM

If there is a delay in verifying insurance coverage, I authorize the Phospholine Iodide QuickStart Program pharmacy to dispense a free initial supply of Phospholine Iodide to eligible patients. Terms and Conditions apply.

Phospholine Iodide (echothiophate iodide for ophthalmic solution) 0.125%

Dosage: _____

Shipping instructions: _____

Deliver product to: Patient home Other

PRESCRIBER SIGNATURE

By signing below, I certify that the prescribed therapy is medically necessary.

Physician printed name _____

Physician signature _____ Date _____

(No stamps) (Dispense as written)

Physician signature _____ Date _____

(No stamps) (Substitutions permitted)

This prescription is valid only if transmitted by means of a facsimile machine directly from the prescriber's office or place of practice.

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.

I, or my authorized representative, hereby authorize my healthcare provider and pharmacy to disclose my health and personal information to Fera Pharmaceuticals, LLC the provider of Phospholine Iodide® and its affiliates, representatives, agents, and contractors (collectively "Fera") in connection with the support services related to patient assistance programs, in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and related federal regulations and rules. The support provided through these programs is not contingent on any further purchase.

Description of Health & Medical Information That May Be Disclosed

My healthcare provider or pharmacy may disclose individually identifiable health and other information that supports my participation in the Phospholine Iodide support programs. Information disclosed may include my name, address, date of birth, medical condition, prescription, treatment, care management, and health insurance; and any other personal information including all demographic information, email addresses, phone numbers, and other information in the possession or control of my healthcare provider or pharmacy. I understand that pharmacy may receive payment from Fera for providing information to Fera pursuant to this authorization, as further set forth below.

Authorized Purposes

The authorized purposes for the disclosure of my health and personal information pursuant to this authorization are: (1) to evaluate my eligibility for inclusion in the Phospholine Iodide support programs and (2) if my participation in the programs is approved, to administer the program.

Expiration of Authorization

Authorization shall expire after one (1) year from the date of my signature.

Acknowledgments

1. I understand that once Fera receives my information based on this authorization, my medical and health information may be subject to re-disclosure and will no longer be protected by federal privacy regulations. I further understand and agree that pharmacy may retain my personal and health information as disclosed under this authorization after this authorization expires for the purposes related to the administration of the support programs. I also understand that the information disclosed may be used in the event of an audit.

2. I understand that signing this authorization is voluntary, and that I may refuse to sign this authorization form. My refusal to sign will not affect my ability to obtain health plan benefits or treatment from my healthcare provider.

3. I understand that I may revoke my authorization at any time by providing a written notice of the same to AllianceRx Walgreens Pharmacy at fax number: 866-412-8411 or by mail at 130 Enterprise Drive, Attention: Manufacturer Free Goods Team, Pittsburgh, PA 15275. However, I understand that if I revoke this authorization, it will not affect prior disclosures made in reliance on this authorization.

4. I understand that I am entitled to receive a copy of this Authorization once it has been signed.

5. I understand and agree to the following:

I agree to communications from Fera Pharmaceuticals, pharmacies, and/or parties acting on their behalf to determine my eligibility for the support programs, and for other non-marketing purposes related thereto.

Patient Printed Name: _____

Signature: _____ Date: _____

Phone Number: _____

*If you are signing this Authorization as a personal representative of the person to receive Phospholine Iodide, please state your relationship to and authority to sign for the Patient (e.g. legal guardian):

_____[*if desired INSERT CONTACT INFORMATION FOR SUBMITTING THIS AUTHORIZATION OR TO ASK QUESTIONS ABOUT IT

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