US-OXE-2600116 08/26

PATIENT ENROLLMENT FORM FOR VA PATIENTS

PHYSICIAN/OFFICE INSTRUCTIONS:

- **Complete all pages of this form for each new prescription.**
- **Forward completed form to the VA pharmacy. The VA pharmacy will fax the form to Accredo Specialty Pharmacy at (888) 454-8488, phone (877) 831-8112 (SAM.gov ACCREDO HEALTH GROUP, INC: LERPSGUE3528).**

*Denotes required field.

PATIENT INFORMATION

Sex: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

*Name (Last, First, Middle Initial): *Date of Birth:

Address: City: *State: ZIP:

*Preferred Phone: Alternative Phone: Best Time to Call: ☐ Day ☐ Evening

Patient Email: Preferred Language:

Caregiver Contact Name: Caregiver Contact Phone Number: Okay to leave message with caregiver? ☐ Yes ☐ No

TREATMENT INFORMATION/PRESCRIPTION (physician to fill out)

*ICD-10 Codes Check all that apply to the treated eye(s)	Neurotrophic Keratoconjunctivitis	Secondary Diagnosis Codes, if applicable
Right eye	☐ H16.231	
Left eye	☐ H16.232	
Bilateral	☐ H16.233	

*Stage of Disease:

If selecting the bilateral ICD-10 diagnosis code, please ensure that you also check the box for "Bilateral Treatment" in the prescription section below and enter the stage of disease for both eyes in the fields to the left.

*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

PRESCRIBING PHYSICIAN INFORMATION

*Prescriber (Title, First Name, Last): If APRN, PA, or RPh Supervising Physician:

NPI Number: *Site/Facility Name:

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

State License #:

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

Preferred Method of Communication: Office Contact Name:

This document and signature authorize the transmission of all necessary information for the prescription to the dispensing pharmacy. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription forms, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. For New York prescribers: In addition to this completed form, provide

***Prescriber Signature (physical signature required):**

Dispense as written Date OR Substitution allowed Date

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PATIENT ENROLLMENT FORM FOR VA PATIENTS, continued

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PATIENT INFORMATION

*Name (Last, First, Middle Initial):

VA PHARMACY INFORMATION

Payment Method: ☐ Credit Card (call pharmacy contact) ☐ E-invoice Tungsten Network

VA Pharmacy Name: Purchase Order #:

If a purchase order # is not populated, email the pharmacy purchasing contact to obtain and confirm purchase price.

Address: City: State: ZIP:

*Primary Purchasing Contact: *Phone #: *Fax #:

Email:

Secondary Purchasing Contact: Phone #: Fax #:

Email:

Primary Clinical Contact: Phone #: Fax #:

Email:

Secondary Clinical Contact: Phone #: Fax #:

Email:

SHIPPING INFORMATION

OXERVATE is shipped directly to the patient. Please list the patient's shipping address if different than on page 1.

Name (Last, First, Middle Initial):

Address: City: State: ZIP: