DURYSTA®
(bimatoprost intracameral implant) 10 mcg

Allergan EyeCue®

Submit at: AllerganEyeCue.com
Call: 1-833-DURYSTA, option 2
Fax: 1-866-676-4069
Hours of operation: Mon-Fri, 9 AM-8 PM ET

***Required information**

PATIENT ENROLLMENT FORM

SUPPORT REQUEST

Please select one option for *Allergan EyeCue*® support*:
(**Please note:** If no box below is selected, comprehensive support will be provided.)

☐ **Comprehensive program support** (eg, DURYSTA® benefit verification, prior authorization/appeals support, DURYSTA® Savings Program, information regarding other patient financial support options)

☐ **DURYSTA® Savings Program only**

OPTIONAL: By checking the box below, I'm requesting *Allergan EyeCue*® to enroll my patient in a specialty pharmacy
(Note: Specialty pharmacy may not be an option for all insurance plans)

☐ **Enroll in specialty pharmacy (optional)**

PATIENT

First name*:_____ Middle initial:_____ Last name*:_____

Date of birth*:_____/_____/_____ Gender*: ☐ Male ☐ Female U.S. resident: ☐ Yes ☐ No

Home phone*:_____ Cell phone:_____ Email:_____

Address*:_____ City*:_____ State*:_____ Zip*:_____

INSURANCE

Patient is uninsured (no third-party or private insurance) ☐ Yes ☐ No

☐ Participating provider ☐ Nonparticipating provider

☐ Insurance card attached (optional: If patient is insured, provide a legible copy of the front and back of the patient's insurance card)

Primary Insurance*

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Insurance company*:_____

Phone*:_____

Insured name*:_____

Insured date of birth*:_____

Policy number*:_____

Secondary Insurance

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Insurance company:_____

Phone:_____

Insured name:_____

Insured date of birth:_____

Policy number:_____

PRESCRIBING PHYSICIAN

Place of service*: ☐ Physician's office ☐ Hospital outpatient ☐ Ambulatory surgical center

Practice/facility name*:_____

Physician name (first and last)*:_____ Physician specialty:_____

Address*:_____ City*:_____ State*:_____ Zip*:_____

Email:_____ Phone*:_____ Fax*:_____

Facility Tax ID No.*:_____ Physician State License No.*:_____ Physician National Provider Identifier (NPI)*:_____

Office Contact Information

Primary office contact*:_____

Phone*:_____ Ext:_____ Fax:_____ Email*:_____

DIAGNOSIS/TREATMENT

Product: DURYSTA®

HCPCS code: J7351 Diagnosis 1*:_____

CPT code: 66030 Diagnosis 2:_____

Please note: We cannot verify benefits without a valid diagnosis code

Drug units*: ☐ 10 units = 1 applicator

DURYSTA® should not be re-administered in a previously treated eye. *Allergan EyeCue*® only supports benefit verification per dosing from the Prescribing Information.
Has the patient received a prior DURYSTA® implant in the treatment eye?* ☐ Yes ☐ No

Anticipated date of treatment:____/____/_____

Important Information: By submitting this form, you are referring the above patient to *Allergan EyeCue*® for patient support and to determine eligibility to receive financial support related to DURYSTA®, a product of AbbVie. By authorizing you to submit this form, the above patient represents that they are an eligible commercially-insured patient and that they will comply with the DURYSTA Savings Program Terms, Conditions, and Eligibility Criteria available and printable at www.durystasavingsprogram.com.

Privacy Notice: For information on how we collect and process your personal data, including the categories we collect, purposes for their collection, and disclosures to third parties, if you are a patient visit https://abbv.ie/PrivacyPatient, if you are a prescriber visit https://abbv.ie/PrivacyHCP.

Through my submission of this Enrollment form, I consent to the collection, use, and disclosure of my personal health data, as described in the Privacy Notice above and in AbbVie's Privacy Notice in the "How We May Disclose Personal Data" section. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "Your Privacy Choices" on AbbVie's website. If you are a prescriber, please share this information with your patient.

Please see Important Safety Information on the following page.

Please see accompanying full Prescribing Information or visit https://www.rxabbvie.com/pdf/durysta_pi.pdf

DURYSTA Program Terms and Conditions

1. This offer is valid only for patients 18 years of age or older who have commercial insurance coverage for DURYSTA® (bimatoprost intracameral implant). **2.** This offer is not valid for use by patients enrolled in Medicare, Medicaid, or other federal or state programs (including any state pharmaceutical assistance programs), or private indemnity or HMO insurance plans that reimburse you for the entire cost of your prescription drugs. Patients may not use this offer if they are Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. This offer is not valid for cash-paying patients. **3.** Depending on insurance coverage, most eligible insured patients may pay as little as $0 for each eye, up to one (1) DURYSTA implant per eye. This offer applies to the implant only and does not apply to costs for any other medication, procedure, or diagnostic service. Check with healthcare provider and insurance plan for discount. Maximum reimbursement limit of $4,200.00 per patient applies; patient out-of-pocket expense will vary. **4.** Claims must be submitted within 365 days of the treatment date and must include a copy of (a) an Explanation of Benefits (EOB) for DURYSTA, (b) DURYSTA Reimbursement Request Form, and (c) documentation from the physician's office indicating the product code, the patient-paid amount, and the diagnosis of an FDA-approved indication. **5.** Patients and healthcare providers may not seek reimbursement for value received from the DURYSTA Savings Program from any third-party payers. **6.** AbbVie reserves the right to rescind, revoke, or amend this offer without notice. **7.** Offer good only in the USA, including Puerto Rico and Guam. Patients residing in or receiving treatment in certain states may not be eligible to participate in this program. **8.** Void if prohibited by law, taxed, or restricted. **9.** This offer is not transferable. The selling, purchasing, trading, or counterfeiting of this offer is prohibited by law. **10.** This offer has no cash value and may not be used in combination with any other discount, coupon, rebate, free trial, or similar offer for the specified prescription. **11.** This offer is not health insurance. **12. By redeeming this offer, patient represents they meet the eligibility criteria above and patient understands and agrees to comply with the terms and conditions of this offer. 13. To learn about AbbVie's privacy practices and your privacy choices, visit https://abbv.ie/corpprivacy.**

For questions about this program, please call 1-833-DURYSTA (833-387-9782).

Program managed by IQVIA Inc. on behalf of AbbVie.

USES

DURYSTA® (bimatoprost intracameral implant) is a prescription medicine to reduce eye pressure (also called intraocular pressure, or IOP) in patients with open angle glaucoma or high eye pressure (ocular hypertension).

IMPORTANT SAFETY INFORMATION

DURYSTA should not be used if:

- You have any infection or suspected infection in your eye or surrounding eye area
- You have corneal endothelial cell dystrophy, a condition in which the clear front layer of your eye (cornea) has lost its ability to work normally and can cause vision problems
- You have had a corneal transplant or cells transplanted to the inner layer of the cornea (endothelial cell transplant)
- The sack that surrounds the lens of your eye (posterior lens capsule) is missing or torn
- You are allergic to any of its ingredients

DURYSTA may cause side effects involving the cornea, including increased risk of loss of cells from the inner layer of the cornea. You should not receive DURYSTA more than once in each eye. DURYSTA should be used with caution if you have a limited reserve of the cells lining the inner layer of the cornea.

DURYSTA should be used with caution if you have narrow or obstructed iridocorneal angles (the space where the iris, the colored part of the eye, and cornea meet).

DURYSTA may cause swelling of the macula, the center spot of the retina (back of the eye). DURYSTA should be used with caution if your eye does not have a lens, if you have an artificial lens and a torn posterior lens capsule, or if you have any risk factors for swelling of the macula.

DURYSTA may cause inflammation inside the eye or make existing inflammation worse.

DURYSTA may cause increased brown coloring of the iris, which may be permanent.

Eye injections have been associated with infections in the eye. It is important that you contact your doctor right away if you think you might be experiencing any side effects after an injection, including eye redness, sensitivity to light, eye pain, or a change in vision. Your doctor should monitor you following DURYSTA administration.

The most common side effect involving the eyes reported in patients using DURYSTA was eye redness. Other common side effects reported were feeling like something is in the eye, eye pain, being sensitive to light, a blood spot on the white of the eye, dry eye, eye irritation, increased eye pressure, a loss of cells on the inner layer of the cornea, blurry vision, inflammation of the iris, and headache.

You are encouraged to report negative side effects of prescription drugs to the FDA.
Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

If you are having difficulty paying for your medicine, AbbVie may be able to help. Visit AbbVie.com/myAbbVieAssist to learn more.

Please see accompanying full Prescribing Information or visit https://www.rxabbvie.com/pdf/durysta_pi.pdf

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