THE DEXYCU ASSURANCE PROGRAM REQUEST FORM

DEXYCU® (dexamethasone intraocular suspension) 9%

The DEXYCU Assurance Program Request Form

The Explanation of Benefits (EOB) forms for the patient(s) listed below have been provided to the DEXYCU Assurance Program for review. So that the DEXYCU Assurance Program can provide reimbursement support services for the listed patient(s) and, if program requirements are met, provide a replacement unit of DEXYCU for Commercially insured and Medicare Advantage patients, the Office Certification at the bottom of this form must be signed by either the physician or the administrator and faxed to the DEXYCU Assurance Program at 1-908-450-1701.* EOB forms must be faxed along with this completed form.

PATIENT INFORMATION

FIRST NAME	LAST NAME	DOB	DATE OF SURGERY	PHYSICIAN NAME	AUTHORIZATION NUMBER	AUTHORIZATION DATE	INSURANCE CARRIER

Facility Name: _____ **License #:** _____

Facility Address: _____ **DEA #:** _____

Office Certification

My signature below certifies that the patient(s) named above is/are my patient(s) or patient(s) of this surgery center and that the information provided is, to the best of my knowledge, complete and accurate. I have obtained each patient's authorization or have confirmed that each patient's authorization had been obtained, to disclose his/her personal and health information to the DEXYCU Assurance Program to use and to disclose as necessary in connection with the possible provision of patient and/or reimbursement support services. I consent to EyePoint Pharmaceuticals' representatives and agents contacting me and this surgery center to confirm receipt of DEXYCU or to provide additional information about DEXYCU and the DEXYCU Assurance Program. I certify that I and this surgery center will not seek reimbursement from any third party for the support EyePoint provides for the patient through the Assurance Program. I and this surgery center agree that EyePoint Pharmaceuticals may change or terminate any of the DEXYCU Assurance Program services at any time without notice.

Name/Title: _____ **Contact email or phone number:** _____

Signature: _____ **Date:** _____

Please fax completed and signed form to 1-908-450-1701.

DEXYCU Assurance Program services are subject to change without notice. The DEXYCU Assurance Program is valid ONLY for patients with Commercial or Medicare Advantage (private or non-governmental) insurance. It is not valid for patients who are Government beneficiaries or whose prescription drugs are covered, in whole or in part, under Medicaid, Medicare, a Medicare Part D plan, TRICARE, CHAMPUS, Puerto Rico Government Health Insurance Plan, or any other state or federal healthcare program. Patients who become Government beneficiaries during their enrollment period will no longer be eligible for the program as of the date they become a Government beneficiary. Patients must be over the age of 18 and a resident of the United States. EyePoint does not guarantee reimbursement. Facility acquisition cost is determined after application of any volume-based discount.

*Eligibility for the replacement unit described herein is limited to 120 days from date of service (i.e., administration date). Claims must be received by September 30, 2020.

EyePoint® Pharmaceuticals

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