EyePoint Assist℠ Program

EyePoint Assist is a free program offered to you from EyePoint Pharmaceuticals. EyePoint Assist works on your behalf to research your health insurance coverage and to assist with determining your eligibility for financial assistance through the EyePoint Assist Copay Program or Patient Assistance Program ("the Program"). The Patient Assistance Program provides free medication for patients who meet certain financial and medical conditions, and who do not have a health care plan, or if your plan will not pay for DEXYCU® (dexamethasone intraocular suspension) 9%. We assist people who may have a health care plan as well as those who do not.

Please complete this section if you would like EyePoint Assist to investigate financial assistance options for DEXYCU.

Date of Birth: _____ **Annual Household Income: $** _____ **Number in Household (including patient):** _____

Primary Insurance: ☐ **Medicare** ☐ **Medicare Advantage** ☐ **Commercial/Private** ☐ **Medicaid** ☐ **Other:** _____

I understand that EyePoint Pharmaceuticals, Inc., including any agents EyePoint engages to administer or otherwise support the Patient Assistance Program (collectively, "EyePoint") may contact me to request verification of any information provided or requested on this form, which I agree to provide personally or through my employer or my insurance or other benefit provider. Completion of this form does not guarantee approval for the Program.

I understand that EyePoint reserves the right, at any time and without notice to me, to modify and/or discontinue any or all Programs, including modification of eligibility criteria, covered medications and immediate termination of assistance provided by the Program.

I certify that: (i) all information provided above is correct and complete to the best of my knowledge, and that I have an obligation to update EyePoint using the contact information herein, of any changes in my financial status or insurance coverage: (ii) if approved for the Program, I will not seek reimbursement for DEXYCU from any government program or third-party payor; (iii) if I am a member of a Medicare Part D plan, I will not apply or claim the cost of any Program drug(s) and/or device(s) toward my true out-of-pocket costs; (iv) I will notify my insurance or other benefit provider of my receipt of any drug(s) and/or device(s) through the Program, if required by those providers; and (v) I understand that the Program does not affect any administration fees my prescriber may charge in accordance with his or her normal billing policies.

Patient/Legal Representative Signature: _____ **Date:** _____

If Legal Representative, Print Name and Indicate Relationship: _____

Notice of Release of Information

For us to help, we need to look at, use and disclose your protected health information (PHI). Your health care provider and health care plan can disclose your PHI to us only with your written authorization. By signing this authorization form, you are authorizing your health care provider and health care plan to release your PHI to us, and you are authorizing us to disclose your PHI as necessary to perform services for you. Once you sign this form and it is sent back to us by you or your health care provider on your behalf, we can start to provide these services.

You can choose not to agree to this authorization; however, it is important for you to understand that we cannot provide our services without your authorization. This means you might need to pay for DEXYCU on your own.

Patient Authorization to Disclose/Use Health Information

Please read through this information carefully. If you have any questions, talk to your health care provider's office or call us at **1-888-367-5166**.

I hereby authorize my health care providers, health care plans, insurers or programs that provide me health care benefits and any specialty pharmacies to disclose to EyePoint Pharmaceuticals and its representatives (including AppianRx) and contractors (together "the Parties") my protected health information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act and regulations thereunder, as amended). This includes all my health records relating to my treatment, information about my health care plan benefits and any information having a bearing on my health or my treatment with DEXYCU.

My PHI may be used and/or disclosed only in these ways: operating and administering of the EyePoint Assist program, reviewing and providing assistance in connection with my health care plan coverage for DEXYCU, applying to financial support from EyePoint Assist, determining eligibility for alternative forms of coverage and sources of funding, tracking my use of DEXYCU, and for operation and administrative purposes of EyePoint Pharmaceuticals authorized representatives.

This authorization and notice of release are effective for 3 years from the date set forth below with my signature. Once my PHI is disclosed, I know that my PHI might not be covered by any federal law that restricts the use and disclosure of my PHI. There is no guarantee that my PHI might not be released to a third party. This third party might not need to follow the conditions of this authorization and notice of release. However, the Parties agree to protect my PHI by using and disclosing it only for the purposes authorized herein or as required by law.

I know I can choose not to sign this form. I may withdraw authorization at any time and for any reason. This will not affect my eligibility to obtain medical treatment with DEXYCU and will have no impact on my treatment by my health care provider. To withdraw authorization, I must send a written notice to EyePoint Pharmaceuticals. It can be sent by fax to **1-866-990-1994** or by mail to **EyePoint Pharmaceuticals, EyePoint Assist Program, c/o AppianRx, LLC. 6330 West Loop, 7th Floor, South Bellaire, TX 77401**. The Parties shall provide timely notification of my withdrawal (revocation) to my health care providers, health care plans, insurers or programs that provide me health care benefits and any specialty pharmacies. Once they receive and process the notice of withdrawal (revocation) of this authorization, they may no longer disclose my PHI to the Parties. However, cancelling this authorization will not affect the Parties' ability to use and disclose my PHI that it has already received (unless the laws of my state prevent the Parties from continuing to use and disclose such PHI). This withdrawal goes into effect once it is received by EyePoint Pharmaceuticals. If I do not sign this form or if I withdraw or revoke my authorization, EyePoint Pharmaceuticals will not be able to help me with the EyePoint Assist program.

Patient Authorization

I hereby authorize the use and disclosure of my PHI as described in this Patient Authorization and Notice of Release

Patient/Legal Representative Signature: _____ **Date:** _____

If Legal Representative, Print Name and Indicate Relationship: _____

Contact Phone of Legal Representative: _____

EyePoint PHARMACEUTICALS

01/2020
US-DEX-2000009