EyePoint ASSIST℠
COVERAGE YOU CAN COUNT ON

Copay Assistance Program: Patient Reimbursement Form

Patients may pay as little as $25 for DEXYCU® (dexamethasone intraocular suspension) 9%

Patients with commercial or private insurance that covers **DEXYCU** for the approved indication are eligible for the Copay Program. Patient must be a resident of the United States. The program does not have an income eligibility requirement and there is a maximum assistance level of $350. Patient will pay as little as the first $25 of the copay for **DEXYCU**. Other terms, conditions, and restrictions may apply.

The Explanation of Benefits (EOB) forms for the patient(s) listed below have been provided or submitted with this form to the EyePoint Assist program for review. So that the EyePoint Assist program can provide reimbursement support services for the listed patient(s) and, if needed, process payment for the **DEXYCU** Patient Reimbursement Program for commercially insured patients, the Office Certification at the bottom of this form must be signed by either the physician or the administrator and faxed to the EyePoint Assist℠ program at 1-908-926-2648.

PATIENT INFORMATION

FIRST NAME	LAST NAME	DOB	DATE OF SURGERY	PHYSICIAN NAME	PHYSICIAN NPI

Facility Name: _____

Facility Address: _____

Facility NPI: _____

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 EyePoint Assist 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 EyePoint Assist 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 Copay Assistance Program. I and this surgery center agree that EyePoint Pharmaceuticals may change or terminate any of the EyePoint Assist program services at any time without notice.

Name/Title: _____

Signature: _____ **Date:** _____ **Phone:** _____

Billing Contact Name (if different than above)**:** _____

Phone: _____ **Fax:** _____ **Facility Tax ID:** _____

Payment Method: ☐ **eCheck** (sent via fax) ☐ **EFT—Routing #:** _____ **Account #:** _____

Please fax completed and signed form to 1-908-926-2648.

EyePoint Assist program services are subject to change without notice. The DEXYCU Reimbursement Program is valid ONLY for patients with commercial (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 or Medicare Advantage 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. Claims must be submitted within one year of date of surgery.

DEXYCU® (dexamethasone intraocular suspension) 9% | EyePoint Pharmaceuticals

01/2021
US-DEX-2100005