IZERVAY My Way℠ Enrollment Form

izervay my way℠ (avacincaptad pegol intravitreal solution) 2 mg

Phone: 1-888-C5MYWAY (1-888-256-9929) **Fax:** 1-833-C5MYWAY (1-833-256-9929)
Email: Support@IZERVAYMyWay.com **Website:** IZERVAYecp.com/PatientSupport

To enroll, simply complete this form and email it to Support@IZERVAYMyWay.com or fax it to 1-833-C5MYWAY (1-833-256-9929) to receive tailored support related to coverage and affordability for IZERVAY. Ensure all required fields are completed before sending.

Sections indicated by an asterisk (*) are required.

STEP 1 Services requested

- ☐ Benefits investigation only
- ☐ Insurance-related support (prior authorization, appeal, replacement)
- ☐ Financial assistance (nonprofit referrals, commercial copay screening)
- ☐ Patient assistance program (for uninsured and underinsured patients)
- ☐ Assistance with all services

STEP 2 Patient information

First name*: _____ Last name*: _____

Preferred name (if different than first name): _____

Date of birth (mm/dd/yyyy)*: _____ Gender*: ☐ Male ☐ Female

Address*: _____

City*: _____ State*: _____ ZIP Code*: _____

Preferred phone*: _____ ☐ Home ☐ Mobile Email: _____

Preferred language: ☐ English ☐ Spanish ☐ Other: _____ Alternate contact name: _____

Relationship: _____ Alt. phone: _____ Has patient started therapy?* ☐ Yes ☐ No

Treatment start date: _____ OK to call patient if their signature is missing on this form? ☐ Yes ☐ No

STEP 3 Insurance information

Does the patient have insurance?* ☐ Yes ☐ No

If the patient is insured, please complete the table below. (OPTIONAL: attach front and back copies of the patient's insurance cards.)

	Primary insurance*		Secondary insurance	
Insurance name*				
Policyholder name and date of birth (if not patient)*		___/___/_____ mm/dd/yyyy		___/___/_____ mm/dd/yyyy
Policyholder ID number*				
Group number*				
Insurance phone*				

☐ Select this box if you would like your patient screened for eligibility for the **IZERVAY Commercial Copay Program**. For complete terms and conditions, please visit IZERVAYecp.com/CommercialCopayTermsAndConditions.

If Patient Assistance Program screening is requested, please include the following*:

Gross annual income: ☐ $0–$50,000 ☐ $50,001–$100,000 ☐ $100,001–$150,000 ☐ >$150,000

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STEP 4 Diagnosis and prescription information

Please provide the appropriate ICD-10-CM diagnosis code(s) to the highest level of specificity. For additional coding information, please visit **IZERVAYecp.com/PatientSupport**

Diagnosis code(s)*:	**Right eye**	**Left eye**	**Bilateral**
Dry (nonexudative) AMD, advanced atrophic without subfoveal involvement	☐ H35.3113	☐ H35.3123	☐ H35.3133
Dry (nonexudative) AMD, advanced atrophic with subfoveal involvement	☐ H35.3114	☐ H35.3124	☐ H35.3134

Dosage*: ☐ IZERVAY 2 mg (0.1 mL of 20 mg/mL solution) administered by intravitreal injection to each affected eye once monthly (approximately every 28 ± 7 days) for up to 12 months, NDC: 82829-002-01 Quantity: ☐ 1 vial ☐ 2 vials

STEP 5 Prescriber information

Place of Service*: ☐ Physician Office ☐ Hospital Outpatient Department (HOPD) ☐ Ambulatory Surgery Center (ASC) ☐ Veterans Affairs (VA) Facility

Required for HOPD/ASC/VA Place of Service*:

HOPD, ASC, or VA Site Name: _____

Place of Service ZIP Code: _____

Prescribing physician first and last name*: _____

Practice name*: _____

Address*: _____

City*: _____ State*: _____ ZIP Code*: _____

Prescriber tax ID #*: _____ Prescriber NPI #*: _____

Group NPI #: _____ PTAN #*: _____

State License #*: _____ Office contact name: _____

Contact phone*: _____ Contact fax*: _____ Email*: _____

Preferred contact method*: ☐ Phone ☐ Fax ☐ Email

Preferred times*: ☐ Morning ☐ Afternoon ☐ Evening Specific time: _____

Is Specialty Pharmacy required for dispensing? ☐ **Yes** ☐ **No**

STEP 6 Healthcare provider certification and authorization*

☐ I certify that, to the full extent required by applicable law, I have obtained written permission from my patient named above (or from the patient's legal representative) to release to the patient support program, IZERVAY My Way ("the Program"), the patient's personal health information, both as provided on this form and such other personal health information as the Program may need (1) to perform a preliminary verification of the patient's insurance coverage for IZERVAY, (2) to assess the patient's eligibility for participation in the Program, (3) to enroll the patient in the Program, (4) to provide reimbursement support and other services to the patient in connection with the patient's prescription(s), and (5) for the other purposes identified on the Patient Authorization for Use and Disclosure of Personal Health Information. I agree that the Program may contact me, including without limitation via email, fax, and telephone, to seek additional information relating to the Program, IZERVAY, or information contained on this form. I understand that any IZERVAY provided at no charge to the patient is provided on a complimentary basis. I will not submit or cause to be submitted any claims for payment or reimbursement for such products to any third-party payer, including a federal healthcare program. If I am or become in possession of such product, I will not resell or attempt to resell the product.

▶ _____ _____

Healthcare provider signature **Date (mm/dd/yyyy)**

▶ _____

Healthcare provider name

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If you are a commercially insured patient and meet eligibility criteria, would you like to be enrolled in the IZERVAY Commercial Copay Program? ☐ Yes ☐ No

If yes, IZERVAY My Way will determine your eligibility and initiate your enrollment. Please see complete terms and conditions available at IZERVAYecp.com/CommercialCopayTermsAndConditions.

Patient Authorization for Use and Disclosure of Personal Health Information*

I authorize my healthcare providers and health plans to disclose my personal health information related to this authorization for the use or potential use of IZERVAY, including my personal contact information on this form (collectively, my "Information"), to the patient support program called IZERVAY My Way (the "Program") so that the Program may use and disclose the Information in order to: (1) establish my benefit eligibility; (2) communicate with my healthcare providers and health plans about my benefit and coverage status and my medical care; (3) provide support services, including facilitating the provision of IZERVAY to me, as well as any information or materials related to such services or Iveric Bio products, including promotional or educational communications; (4) evaluate the effectiveness of Iveric Bio support programs; (5) report safety information, including in communications with the US Food and Drug Administration and other government authorities; (6) contact me regarding this form or my use or potential use of IZERVAY and provide me with related patient support communications, including messages left for me that disclose that I take or may take IZERVAY; and (7) allow Iveric Bio to analyze the usage patterns and the effectiveness of Iveric Bio products, services, and programs and help develop new products, services, and programs, and for other Iveric Bio general business and administrative purposes. I understand that my pharmacy provider(s) may receive remuneration in exchange for the provision of my Information as authorized above, and that once my Information has been disclosed to the Program, federal privacy law may no longer restrict its use or disclosure and that it may be redisclosed to others. I also understand, however, that the Program plans to use and disclose my Information only for the purposes described above or as required by law. I understand that if I refuse to sign this Authorization, that will not affect my right to treatment or payment benefits for healthcare. I also understand that if I sign, I may later withdraw this Authorization by sending written notice of my withdrawal from the Program to IZERVAY My Way at PO Box 5490, Louisville, KY 40255, and that such withdrawal will not affect any uses and disclosures of my Information prior to the Program's receipt of the notice. I am entitled to a copy of this signed Authorization, which expires 10 years from the date it is signed by me or such timeframe as allowed by law.

I have read and agree to the Patient Authorization information on this page.

▶ _____ _____

Patient/Authorized representative signature **Date (mm/dd/yyyy)**

_____ _____

Print name **Patient date of birth (mm/dd/yyyy)**

INDICATION

IZERVAY™ (avacincaptad pegol intravitreal solution) is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

- IZERVAY is contraindicated in patients with ocular or periocular infections and in patients with active intraocular inflammation.

WARNINGS AND PRECAUTIONS

- Endophthalmitis and Retinal Detachments
  - Intravitreal injections, including those with IZERVAY, may be associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering IZERVAY in order to minimize the risk of endophthalmitis. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately.
- Neovascular AMD
  - In clinical trials, use of IZERVAY was associated with increased rates of neovascular (wet) AMD or choroidal neovascularization (7% when administered monthly and 4% in the sham group) by Month 12. Patients receiving IZERVAY should be monitored for signs of neovascular AMD.
- Increase in Intraocular Pressure
  - Transient increases in intraocular pressure (IOP) may occur after any intravitreal injection, including with IZERVAY. Perfusion of the optic nerve head should be monitored following the injection and managed appropriately.

ADVERSE REACTIONS

- Most common adverse reactions (incidence ≥5%) reported in patients receiving IZERVAY were conjunctival hemorrhage, increased IOP, blurred vision, and neovascular age-related macular degeneration.

Please see full Prescribing Information for more information.