IZERVAY My Way℠ Enrollment Form

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 all pages 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 (eg, prior authorization information, appeal information)
- ☐ Financial assistance (eg, information on potential financial assistance sources, commercial copay screening)
- ☐ Patient assistance program (for eligible 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

First/next treatment date (estimated)*: _____ OK to call patient if their signature is missing on this form? ☐ Yes ☐ No

STEP 3 Insurance information

Does the patient have medical 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*				

†If secondary insurance is added, all fields are required.

☐ 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*:

Patient gross annual household income: ☐ $0–$50,000 ☐ $50,001–$100,000 ☐ $100,001–$150,000 ☐ >$150,000

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

Sections indicated by an asterisk (*) are required.

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

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*: _____ Group name: _____
Address*: _____
City*: _____ State*: _____ ZIP Code*: _____
Prescriber tax ID #*: _____ Prescriber NPI #*: _____
PTAN/Medicare Provider ID #†: _____
Prescriber 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

†PTAN required for Medicare Part B.

STEP 6 Healthcare provider certification and authorization*

☐ By signing below, I hereby attest that I am the prescribing healthcare provider, or an authorized agent in the healthcare provider's practice signing on behalf of the healthcare provider, and that IZERVAY has been prescribed for this patient based on the treating healthcare provider's professional judgment of medical necessity. To the best of my knowledge, the patient and physician information in this form is complete and accurate. I also certify that this prescription complies with all applicable state and local laws. I agree to notify the Program if I become aware at any time in the future of changes in my patient's circumstances that would affect his or her eligibility, including but not limited to changes in health insurance status or coverage, financial status, United States residency status, or the use for which IZERVAY has been prescribed for this patient. I understand that Astellas Pharma US, Inc. ("Astellas") reserves the right to change or terminate the Program at any time, or to refuse to provide complimentary IZERVAY under the patient assistance program to any patient. I understand that completing this enrollment form does not guarantee that assistance will be provided to my patient. If my patient obtains IZERVAY via the patient assistance program, I understand that (a) any medication supplied under the patient assistance program is for the use of the patient named on this form only and shall not be sold, traded, bartered, transferred, returned for credit, or submitted to any third party (including the patient or any third-party payor) for reimbursement; (b) I will receive and secure my patient's medication at my office separate from commercially purchased medication until it's dispensed to my patient, when applicable; (c) I will comply with and abide by my State practitioner dispensing laws for authorized prescribers, when applicable; and (d) the provision of free drug as part of the patient assistance program is not contingent on any future purchase or prescribing of IZERVAY. I certify that a copy of the Patient Authorization statement has been given to the patient named on page 1 or their representative and that I have provided my patient with a description of IZERVAY My Way Program.

▶ _____ _____
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

I have read and agree to the Patient Authorization **on pages 3-5** of the IZERVAY Enrollment Form.

▶ _____ _____

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

_____ _____

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

By signing above, I authorize my doctors, pharmacy, and other healthcare providers, and my health insurance plan, to disclose to Astellas Pharma US, Inc. ("Astellas") and its third-party suppliers, vendors, and other service providers supporting IZERVAY My Way℠ (collectively, the "Service Providers") personally identifiable information about me (my "Personally Identifiable Information") (for example, my name, Social Security number, address, insurance policy number, and income) and my medical condition (for example, my diagnosis or medications). This Personally Identifiable Information can include spoken or written facts about my health and insurance benefits. It can include copies of records from my healthcare providers or health plans about my health or healthcare.

I understand that my healthcare providers and my pharmacy may receive remuneration, or payment, for disclosing my Personally Identifiable Information pursuant to this Authorization.

I understand that the Service Providers may be compensated by Astellas.

Astellas and/or the Service Providers will use and disclose my Personally Identifiable Information to:

- administer and determine my eligibility for participation in IZERVAY My Way (the "Program");
- contact me by phone or mail to request further information, discuss the application process, and/or administer the Program;
- assist me with my enrollment in the Program and verify my health insurance coverage;
- coordinate the support available to me through the Program, which may include providing educational materials and other support;

- assist with analyses of the efficiencies and performance of the Program and the Service Providers;
- aggregate my information with that of other Program participants and analyze that information to improve the Program;
- create de-identified information for use only for legitimate business purposes.

I specifically authorize Astellas and the Service Providers to use and disclose my Personally Identifiable Information for the purposes described above.

I authorize Astellas and Service Providers to access my consumer report from a consumer reporting agency (credit bureau), other credit information, and public record information (collectively "Financial Records") to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility for assistance from the Program. I authorize Astellas and Service Providers to use my demographic information, including but not limited to Social Security number, date of birth, name, and/or address, as needed to access such Financial Records to estimate my income in conjunction with the eligibility determination process performed to determine my eligibility under the Program. Astellas and Service Providers reserve the right to ask for additional documents and information at any time. I agree to notify my healthcare providers if I become aware in the future of changes that would affect my eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, and United States residing status.

I understand that Astellas and Service Providers will make reasonable efforts to keep my Personally Identifiable Information private; however, I understand that once my Personally Identifiable Information has been disclosed to the Service Providers, it may no longer be protected under federal and state privacy law and could be disclosed to others.

I further understand that if I decline to sign this authorization, that will not affect my eligibility for health plan benefits and treatment by my healthcare providers, but it will mean I cannot participate in the Program or receive the assistance, support, and education available through the Program.

I understand that I may revoke this authorization at any time by calling IZERVAY My Way at 1-888-256-9929 or emailing them at Support@IZERVAYMyWay.com. If I do revoke this authorization, none of the persons and entities whom it authorizes to use and disclose my Personally Identifiable Information may rely on the authorization after IZERVAY My Way receives my notice of revocation, but I understand that the uses and disclosures previously made in reliance on the authorization will not be deemed invalid. This authorization will

last for three (3) years from the date of my signature on this form or until I am no longer receiving IZERVAY or enrolled in IZERVAY My Way, whichever is later, unless a shorter period is required by law.

I know I have a right to see or copy the information my healthcare providers or payers have given to the Service Providers.

This Authorization Statement is governed by and interpreted in accordance with the laws of the state of Illinois, excluding Illinois conflict of law rules, and applicable federal law.

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. Over 24 months, the rate of neovascular (wet) AMD or choroidal neovascularization in the GATHER2 trial was 12% in the IZERVAY group and 9% in the sham group. 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.