EpioxaCareConnect™

For Support call: 1-855-5-EPIOXA M-F, 8am-8pm ET
Fax the completed form to: 1-800-839-6276

Patient Enrollment Form

(to be completed by provider)

Patient Information

First Name:	Middle Initial:	Last Name:
Date of Birth:		Gender: ☐ F ☐ M ☐ U
Physical Address:		
City:	State:	Zip Code:
Email:		Phone Number:
Preferred Language:		
Legally Authorized Representative (*required if under 18):		
First Name:	Middle Initial:	Last Name:
Date of Birth:		
Physical Address:		
City:	State:	Zip Code:
Email:		Phone Number:

Has treatment been scheduled? ☐ Yes ☐ No Date: _____

If No, anticipated date of treatment Date: _____

Optional: Faxing chart notes supports the Prior Authorization process.

Insurance Information **Attach both sides of insurance cards.**

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other
☐ Uninsured

Primary Insurance:	Secondary Insurance:
Policy ID #:	Policy ID #:
Group #:	Group #:
Policyholder First and Last Name:	Policyholder First and Last Name:
Insurance Phone:	Insurance Phone:
Policyholder Date of Birth:	Policyholder Date of Birth:

Household Income if Applying for Patient Assistance Program

Total Household Income $ _____	Number of household members (including patient) _____

Site of Care

Name of Facility:		
Address of Facility:		
City:	State:	Zip Code:
Facility Phone:	Facility Fax:	
NPI #:	Facility Tax ID #:	
Place of Service (POS) Codes:	☐ POS 11- Office ☐ POS 19- Off Campus- Outpatient Hospital: ☐ POS 22- On Campus- Outpatient Hospital ☐ POS 24- Ambulatory Surgical Center ☐ Other	

Prescriber Information

First Name:	Last Name:	
Physical Address:		
City:	State:	Zip Code:
NPI #:	Tax ID #:	State License #:
Clinic/Hospital Affiliation:		
Office Contact Name:		
Office Phone:	Office Fax:	
Office Email:		
Preferred method of communication: ☐ Email ☐ Phone ☐ Fax		
Prescriber Specialty:		
Was patient referred to you by another physician? ☐ Yes ☐ No		
Referring Provider (if applicable):		
Name:	Specialty:	
City:	State:	
Zip Code:	Phone:	

Prescription Information: EPIOXA™ (riboflavin 5′-phosphate ophthalmic solution)

ICD-10 Diagnosis Code:

- ☐ H18.621: Keratoconus, unstable, right eye
- ☐ H18.622: Keratoconus, unstable, left eye
- ☐ H18.623: Keratoconus, unstable, bilateral
- ☐ Other

Prescriber Signature: _____ Date: _____

Has the patient received prior treatment for condition above?

☐ Yes ☐ No If so, what treatment? _____

Preferred Drug Acquisition

Buy & Bill: ☐ Specialty Pharmacy: ☐

Prescriber Attestation:

By checking the box below, I agree that Glaukos Corporation, its affiliates, agents, representatives, collaborators and service providers (collectively "Glaukos") can use the patient-related information provided for the purposes stated herein. I further certify that the patient is aware of and has expressly consented to and directed the disclosure of their information, which may include Personal Health Information, to Glaukos to enable Glaukos to conduct an insurance coverage investigation and provide insurance reimbursement services related to Epioxa throughout the duration of the patient's treatment and follow-up. My signature certifies that the person named on this form is my patient; that the information provided on this application, to the best of my knowledge, is complete and accurate; and that therapy with Epioxa is medically necessary.

Prescriber Signature: _____ Date: _____

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Patient Enrollment Form

(to be completed by patient or patient representative)

Permission to Release of Personal Information: REQUIRED

☐ By checking this box, providing my personal and health-related information, I consent to Glaukos and its service providers to collect, use and share this information to provide me with the patient support services I am requesting, including providing me with education, product information, and help with insurance coverage or costs. I understand that I can withdraw my consent at any time by contacting Glaukos.

Glaukos Promotional Communications: Optional

☐ By checking this box, I consent to receive Glaukos promotional communications, including via text, email, phone & voicemails, including with automated telephone dialing technology or pre-recorded messages regarding news, products, events, programs, or clinical trials. Message and data rates may apply. I know that I am not required to consent to receiving promotional communications to receive goods or services. I can contact Glaukos at any time to opt-out or reply STOP to stop text messaging.

For more information visit www.Glaukos.com

Patient First Name: _____ Patient Last Name: _____

Patient Signature: _____ Date: _____

***Required if patient is under 18**

Representative First Name: _____ Representative Last Name: _____

Representative Relationship to Patient: _____ Date: _____

Representative Signature: _____

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