EpioxaCareConnect™

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

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

Treatment Date(s): Left: _____ Right: _____ Both: _____

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/Prescription Drug 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 (For U.S. Residents Only)

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:		

Prescription Information:

EPIOXA™ HD (riboflavin 5′-phosphate ophthalmic solution) 0.239% and EPIOXA™ (riboflavin 5′-phosphate ophthalmic solution) 0.177%

*ICD-10 Diagnosis Code: Check all that apply to the treated eye(s)

☐ H18.60X: Keratoconus, unspecified

☐ H18.61X: Keratoconus, stable

☐ H18.62X: Keratoconus, unstable ☐ Other

Quantity: ☐ Right Eye/1 box ☐ Left Eye/1 box ☐ Bilateral/2 boxes *Refills: None*

Directions: *Apply the Epioxa HD drop regimen followed by the Epioxa drop regimen topically to the affected eye(s) as directed.*

Prescriber Signature: _____ Date: _____
Dispense as written (No Stamps)

Prescriber Signature: _____ Date: _____
Substitution allowed (No Stamps)

The prescriber is to comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. ATTN: NEW YORK AND IOWA PROVIDERS, PLEASE SUBMIT ELECTRONIC PRESCRIPTION.

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: _____

PM-US-3306 V2.0 12/2025

GLAUKOS
TRANSFORMING VISION

EpioxaCareConnect™

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

Patient Enrollment Form

(to be completed by patient or patient representative)

Permission to Release of Personal Information: REQUIRED

☐ By signing below, I authorize my healthcare providers, pharmacies, and health insurers to use and to share with Glaukos, Corp., EpioxaCareConnect (ECC), and their representatives, agents, and contractors, including Orsini Specialty Pharmacy, Inc. and IQVIA (collectively "ECC"), my protected health information ("PHI"). This information can include, for example, my name, SSN, medical and pharmacy records, information relating to my medical condition, treatment, and health insurance, as well as all information provided on any prescription, as it relates to my treatment with Glaukos products. I authorize ECC to use this information for the following purposes: (1) to provide financial support services including benefits verification, potential out-of-pocket costs, and eligibility for financial assistance and/or other patient assistance; (2) to contact me by phone, text, email, or mail to provide product support and related services and obtain feedback; (3) to communicate and exchange PHI with my healthcare providers, pharmacies, and health insurers for reasons related to the Program; (4) to analyze the ECC program and test systems and processes for internal business purposes; and (5) to provide me with information, including promotional and product materials, regarding offers, services, programs, educational training, and ongoing support on the use of Glaukos products that may be of interest to me. I understand that once my PHI is shared with Glaukos and ECC as described above, it may not remain protected by federal privacy law, including the Health Insurance Potability and Accountability Act (HIPAA) and could be disclosed to others. I understand that pharmacies may receive payment for the use and disclosure of my PHI as described in this authorization. I further authorize pharmacies to use my PHI to communicate with me about the medicinal product that has been prescribed for me and understand that they may receive a fee for such communication. I understand that some of the use, disclosure, and communication described in this authorization may be for marketing purposes. I understand that I may refuse to sign this authorization and that if I do refuse, it would not affect my rights to treatment or health benefits, but it would prevent me from enrolling in ECC financial and patient assistance programs. I also understand that I may cancel this authorization at any time by calling 1-855-537-4692 and requesting such cancellation, but that any such cancellation will not affect the sharing of my PHI before my cancellation. I understand that I have the right to receive a copy of this authorization when it is signed.

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 under 18**

Representative First Name: _____ Representative Last Name: _____

Representative Relationship to Patient: _____ Date: _____

Representative Signature: _____

PM-US-3306 V2.0 12/2025

GLAUKOS
TRANSFORMING VISION