DURYSTA®
(bimatoprost intracameral implant) 10 mcg

Allergan EyeCue®

Submit at: AllerganEyeCue.com
Call: 1-833-DURYSTA, option 2
Fax: 1-866-676-4069
Hours of operation: Mon-Fri, 9 AM-8 PM ET

*Required information

PATIENT ENROLLMENT FORM

SUPPORT REQUEST

Please select one option for *Allergan EyeCue*® support*:
(**Please note:** If no box below is selected, comprehensive support will be provided.)

☐ **Comprehensive program support** (eg, DURYSTA® benefit verification, prior authorization/appeals support, DURYSTA® Savings Program, information regarding other patient financial support options)

☐ **DURYSTA® Savings Program Only**

OPTIONAL: By checking the box below, I'm requesting *Allergan EyeCue*® to enroll my patient in a specialty pharmacy (Note: Specialty pharmacy may not be an option for all insurance plans)

☐ **Enroll in specialty pharmacy (optional)**

PATIENT

First name*:__________ Middle initial:_____ Last name*:__________

Date of birth*:____/____/____ Gender*: ☐ Male ☐ Female U.S. resident: ☐ Yes ☐ No

Home phone*:__________ Cell phone:__________ Email:__________

Address*:__________ City*:__________ State*:_____ Zip*:__________

INSURANCE

Patient is uninsured (no third-party or private insurance) ☐ Yes ☐ No

☐ Participating provider ☐ Nonparticipating provider

☐ Insurance card attached (optional: If patient is insured, provide a legible copy of the front and back of the patient's insurance card)

Primary Insurance*

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Insurance company*:__________

Phone*:__________

Insured name*:__________

Insured date of birth*:__________

Policy number*:__________

Secondary Insurance

☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other

Insurance company:__________

Phone:__________

Insured name:__________

Insured date of birth:__________

Policy number:__________

PRESCRIBING PHYSICIAN

Place of service*: ☐ Physician's office ☐ Hospital outpatient ☐ Ambulatory surgical center

Practice/facility name*:__________

Physician name (first and last)*:__________ Physician specialty:__________

Address*:__________ City*:__________ State*:_____ Zip*:__________

Email:__________ Phone*:__________ Fax*:__________

Facility Tax ID No.*:__________ Physician State License No.*:__________ Physician National Provider Identifier (NPI)*:__________

Office Contact Information

Primary office contact*:__________

Phone*:__________ Ext:_____ Fax:__________ Email*:__________

DIAGNOSIS/ TREATMENT

Product: DURYSTA®

HCPCS code: J7351 (effective 10/1/20) Diagnosis 1*:__________

CPT® code: 66030 Diagnosis 2:__________

Please note: We cannot verify benefits without a valid diagnosis code

Drug units*: ☐ 10 units = 1 applicator

DURYSTA® should not be re-administered in a previously treated eye. *Allergan EyeCue*® only supports benefit verification per dosing from the Prescribing Information.
Has the patient received a prior DURYSTA® implant in the treatment eye?* ☐ Yes ☐ No

Anticipated date of treatment:____/____/______

IMPORTANT INFORMATION: By submitting this form, you are referring the above patient to *Allergan EyeCue*® for patient support and to determine eligibility to receive financial support related to DURYSTA®, a product of Allergan, an AbbVie company. By authorizing you to submit this form, the above patient represents that they are an eligible commercially insured patient and that they will comply with the DURYSTA® Savings Program Terms, Conditions, and Eligibility Criteria available and printable at DurystaSavingsProgram.com. AbbVie, its affiliates, collaborators, and agents ("AbbVie") will use the information collected about you and your patient to provide and manage *Allergan EyeCue*® services and the DURYSTA® Savings Program and to perform research and analytics on a deidentified basis. For more information about the categories of personal information collected by AbbVie and the purposes for which AbbVie uses personal information, visit www.abbvie.com/privacy. **Please share this information with your patient.**

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Please see accompanying full Prescribing Information or visit https://www.rxabbvie.com/pdf/durysta_pi.pdf