BAUSCH + LOMB

Bausch + Lomb Patient Assistance Program

PO Box 1013
Somerville, NJ 08876
Phone: 866-516-0744
Fax: 866-856-2235

The Bausch + Lomb Patient Assistance Program provides only certain Bausch + Lomb medicines at no cost to patients experiencing financial difficulties. Eligible patients have no prescription coverage. All applications are reviewed on a case-by-case basis to support the Bausch + Lomb Patient Assistance Program's purpose of providing products at no cost to individuals in need.

A PRESCRIPTION IS REQUIRED FOR EACH REQUEST. A completed prescription for an eligible product (please refer to the list on page 3) must be attached with an original signature of the prescribing physician, quantity and directions. This completed form and the prescription must be returned by mail or fax to fulfill the request.

Program Eligibility:

- Patient must be a legal resident of the United States.
- Patient cannot have any government drug coverage such as Medicaid, Veteran's Administration, state programs or qualify for state or federal reimbursement for Bausch + Lomb patient assistance products.
- Patient cannot be enrolled in Medicare Part D.
- Patient cannot have private insurance such as an HMO or PPO.
- Patient cannot have private insurance reimbursement for Bausch + Lomb patient assistance products.
- Patient's yearly household income must be at or below 200% of the FPL. Enrollment will be based on income and household size.

How to Apply:

Patient Instructions:

- Complete and sign page 2 (Patient Information- no signatures stamps).
- Attach copy of most recent Federal tax return.
  — If you do not file a Federal tax return, please attach other proof of yearly household income (such as W-2, 1099, unemployment award letter, social security, disability or pension statement) for everyone living with you.
- Ask your doctor to complete and sign page 3 (Practitioner Information). See below for "Practitioner Instructions."
- Mail form and a copy of proof of income to:
  - Bausch + Lomb Patient Assistance Program, P.O. Box 1013, Somerville, NJ 08876
- **Note:** the patient will need to complete this form each time a refill is requested and submit a valid prescription.

Practitioner Instructions:

- Complete and sign page 3 Practitioner Information (Practitioner section — no signature stamps, please).
  - **The Practitioner must include a valid prescription (with directions, quantity and prescriber signature) for the requested Bausch + Lomb medication(s) on the program in order for Bausch + Lomb to ship the product.** The prescription can be faxed to 866-856-2235 from the provider's office or the original can be mailed. Please do not submit electronic prescriptions (E-Scripts).
  - The Practitioner must include their NPI number AND State License number or DEA.
  - All orders will be shipped to the patient, unless otherwise indicated or program/pharmacy guidelines dictate otherwise.
- If you are assisting a patient in completion of this form, please refer to patient instructions above.

*Reimbursement support will be performed first for selected products, allowing for insurance company coverage denials to be evaluated for patient assistance. Options may also be available for those with insufficient coverage.

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ALL SECTIONS ARE REQUIRED

Patient Information

Name_____

Address_____

City_____State_____Zip_____

Social Security Number_____

Patient Gender: □ Male □ Female

Date of Birth _____

Phone #

Patient Representative for Purposes of Program (if applicable)
I permit the Bausch + Lomb Patient Assistance Program to speak and write to the following person(s) about this form, and I permit the person(s) to sign any documents related to the Program on my behalf:

Name:_____Relationship:_____Phone:_____

1. Is the patient a U.S. resident? □ Yes □No

2. Does the patient have DRUG COVERAGE? **(If yes to any of the following, please submit a copy of the front and back of your insurance card.)**
   Private plan (such as HMO or PPO) □ Yes □ No
   Medicare Prescription Drug □ Yes □ No
   Other Government coverage □ Yes □ No i.e.: Medicaid, Veteran's Administration, state or local programs

3. What is the gross YEARLY HOUSEHOLD INCOME including wages, social security, disability, etc.?
$_____YEARLY

4. How many people, including the patient, live in the household? (please circle) 1 2 3 4 5 6+

I verify that all information provided in this request is complete and accurate. I certify that I am either uninsured or I do not have insurance or any other coverage (including any government-funded program benefits, such as Medicaid and Medicare) for the requested medication. If I am enrolled in Medicare Part D, I certify that I will not seek to count any product that I receive through the Program towards my TrOOP. I further certify that I meet the financial need criteria specified above. I understand I am expected to seek any available state or government assistance before applying to the Program. I agree that I will not submit any claim for reimbursement for any of the products that I receive from the Program from any public or private third party payor. I understand that Bausch + Lomb reserves the right at any time and without notice to modify this application form or modify or discontinue the Program and the related eligibility criteria. I authorize the use of this information on this application to process my request.

Patient or legal guardian's signature (No signature stamps, please) Date

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Practitioner Information/Patient History

Patient Name _____ Patient DOB _____

Patient allergies: None ☐ Known: _____

Please list the names of other medications the patient is currently taking: None ☐

List: _____

Prescriber Name _____ NPI Number _____ State License Number (SLN) & Expiration Date _____

Shipping Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____ ☐ Check here if same as shipping address

Office Contact Person _____ Telephone Number _____ Fax Number _____

Product

The following medications are available from the Bausch + Lomb Patient Assistance Program. A maximum of quantity as listed below of any one product may be specified on any one request. Any request above the specified limit will not be shipped. No substitutions are allowed. Please allow 4-6 weeks for delivery. Please check appropriate ☑ for the medication request below and attach a valid Rx:

Alrex® (loteprednol etabonate ophthalmic suspension) 0.2% 10 mL	**Qty = 1** ☐
Besivance® (besifloxacin ophthalmic suspension) 0.6% 5 mL	**Qty = 1** ☐
Lotemax® Gel (loteprednol etabonate ophthalmic gel) 0.5% 5 g	**Qty = 1** ☐
Zylet® (loteprednol etabonate 0.5% and tobramycin 0.3% ophthalmic suspension) 10 mL	**Qty = 1** ☐
Zirgan® (ganciclovir ophthalmic gel) 0.15% 5 gm	**Qty = 1** ☐
Prolensa® (bromfenac ophthalmic solution) 0.07% 3 mL	**Qty = 1** ☐
Bepreve® (bepotastine besilate ophthalmic solution) 1.5% 10 mL	**Qty = 1** ☐
Timoptic® (timolol maleate ophthalmic solution) in Ocudose® 0.25% (one box of 60 unit dose pipettes)	**Qty = 3** ☐
Timoptic® (timolol maleate ophthalmic solution) in Ocudose® 0.5% (one box of 60 unit dose pipettes)	**Qty = 3** ☐
Lacrisert® (hydroxypropyl cellulose ophthalmic insert) 5 mg Eye Insert (one box of 30 inserts)	**Qty = 1** ☐
Istalol® (timolol maleate ophthalmic solution) 0.5% 5mL (box)	**Qty = 3** ☐

To the best of my knowledge based upon the information provided to me, the patient identified below: (1) does not have public or private prescription insurance coverage for the requested medication or has been denied coverage for the requested medication, and (2) meets the financial need criteria specified above.

My signature below certifies the following:

1. That the product I receive from the Program in response to this request is solely for the use by the patient identified below.
2. That I shall not seek reimbursement, or assist any patient to seek reimbursement, from any insurance provider or payer (public or private) for any of the products provided for free pursuant to the Program.
3. The products provided pursuant to the Program will not be resold nor offered for sale, sample, trade, barter, or used for any other purpose.
4. That the state license information and expiration date provided above is accurate and authorizes me to receive Program product for the identified patient.

That the completed prescription provided with this request was completed and signed by me, and that I have made an independent medical judgment that the prescription is in the best clinical interest of the identified patient.

Practitioner's signature (No signature stamps, please) _____ Date _____

Bausch & Lomb Incorporated will make every effort to grant aid for when needed. This program is limited to available resources and may be revised or discontinued at any time.