EYSUVIS I SAVE PATIENT ACCESS PROGRAM

PHARMACY FAX #: (_____) _____ - _____

PATIENT INFORMATION

FIRST NAME: LAST NAME:

PHONE: ( ) - BIRTH DATE: / / GENDER:

ADDRESS:

CITY: STATE: ZIP:

BIN: PCN #: ICD-10 CODE:

INSURANCE ID #: GROUP #:

PHYSICIAN INFORMATION

PHYSICIAN FIRST NAME: PHYSICIAN LAST NAME:

PHONE: ( ) - NPI #:

OFFICE ADDRESS:

CITY: STATE: ZIP:

FAX NUMBER: ( ) -

TREATMENT

MEDICATION	QUANTITY	REFILLS	INSTRUCTIONS
EYSUVIS™ (loteprednol etabonate ophthalmic suspension) 0.25% NDC: 71571033383	◯ 1	◯ 1 ◯ 3 ◯ 6 ◯ Other:_____	◯ Instill 1-2 drops in each eye 4 times daily for up to 2 weeks ◯ Other:_____ _____

PHYSICIAN SIGNATURE: _____ DATE: / /

kala PHARMACEUTICALS

Please see Full Prescribing Information for EYSUVIS at www.EYSUVIS.com

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