xdemvy®
(lotilaner ophthalmic solution) 0.25%

Prescription Form

for Nationwide Pharmacies Supplying XDEMVY

Prescriber Information

Prescriber Name _____ NPI # _____

Specialty ☐ Ophthalmologist ☐ Optometrist

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Office Contact Name _____ Email _____

Patient Information

Patient Name _____ Date of Birth ____/____/____

Gender ☐ Male ☐ Female

Address _____

City _____ State _____ ZIP _____

Cell Phone _____ Email _____

Preferred Contact ☐ Text ☐ Phone ☐ Email

Attach a copy of the front and back of the patient's prescription benefit card OR complete information below:

Pharmacy Benefit Insurer Name _____

Pharmacy Benefit Insurer Phone _____ Member ID _____ Group Number _____

Subscriber Name (relationship to the patient) _____ Rx BIN _____ Rx PCN _____

Diagnosis Information (Please complete both of the boxes below.)

☐ ***Demodex* blepharitis**

Related ICD-10 codes (Please provide the appropriate ICD-10 codes.) For example:

☐ B88.01 (Infestation by *Demodex* mites) **AND** ☐ At Least One H01 Code _____

It is the responsibility of the healthcare provider to clinically diagnose each patient, verify the available codes, and select the codes that accurately reflect each patient's diagnosis. The information in this guide is for informational purposes only and should not be interpreted as a guarantee of coverage or payment. Contact payers directly for the latest coverage and claims guidance. For current information on ICD-10 codes, please refer to an ICD-10-CM resource. All information is subject to change.

Prescription Information: XDEMVY® (lotilaner ophthalmic solution) 0.25%

Quantity: ____ 10 mL fill in an 11 mL container ____ Refills

Sig: Instill one drop in each eye twice daily (approximately 12 hours apart) for 6 weeks.

Other Instructions _____

"Dispense As Written"/Brand Medically Necessary/ Do Not Substitute/No Substitution/DAW/May Not Substitute	May Substitute/Product Selection Permitted/ Substitute Permissible
Prescriber's Signature: _____	**Prescriber's Signature:** _____
Date: ____/____/____	**Date:** ____/____/____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**."

ATTN: New York and Iowa providers, please submit an electronic prescription.

Submit to the Nationwide Pharmacy Selected to Supply XDEMVY to Your Patient

☐ **BlinkRx**	Phone: 1-833-919-4942 Fax: 1-866-585-4631	☐ **Carepoint Pharmacy**	Phone: 1-855-237-9112 Fax: 1-855-237-9113
☐ **CenterWell Specialty Pharmacy**	Phone: 1-800-486-2668 Fax: 1-877-405-7940	☐ **CVS Specialty Pharmacy**	Phone: 1-800-237-2767 Fax: 1-800-323-2445
☐ **Walgreens Specialty Pharmacy**	Phone: 1-800-424-9002 Fax: 1-800-874-9179	☐ **Walmart Specialty Pharmacy**	Phone: 1-877-453-4566 Fax: 1-866-537-0877

For local pharmacies that dispense XDEMVY, visit **xdemvyhcp.com/how-to-prescribe**.

For questions regarding this XDEMVY prescription form, contact Tarsus Connect™ at **xdemvyhcp.com** or **1-866-846-3092**.

Indication and Usage

XDEMVY® (lotilaner ophthalmic solution) 0.25% is indicated for the treatment of *Demodex* blepharitis.

Important Safety Information

WARNINGS AND PRECAUTIONS

Risk of Contamination: Do not allow the tip of the dispensing container to contact the eye, surrounding structures, fingers, or any other surface in order to minimize contamination of the solution. Serious damage to the eye and subsequent loss of vision may result from using contaminated solutions.

Use with Contact Lenses: XDEMVY contains potassium sorbate, which may discolor soft contact lenses. Contact lenses should be removed prior to instillation of XDEMVY and may be reinserted 15 minutes following its administration.

ADVERSE REACTIONS: The most common adverse reaction with XDEMVY was instillation site stinging and burning which was reported in 10% of patients. Other ocular adverse reactions reported in less than 2% of patients were chalazion/hordeolum and punctate keratitis.

Please click here for full Prescribing Information.

This Patient Authorization will enable Tarsus Connect to assist the eye care practice with insurance support for the patient's XDEMVY prescription coverage.
It is NOT REQUIRED by a nationwide pharmacy to process the patient's XDEMVY prescription.

HIPAA Authorization

By signing this authorization, I authorize my health plans, physicians, long-term care and other healthcare providers, pharmacies, and health insurance companies, and each of their respective representatives, employees, staff, and agents (collectively "Providers") to use and disclose my Protected Health Information ("PHI"), which is defined to mean all information regarding my health care, including but not limited to, my name, address and phone number, information relating to my medical condition, treatment, care management, and health insurance, as well as information provided on this form and any prescription to Tarsus Pharmaceuticals and its representatives or agents (collectively "Tarsus"). I authorize and direct my Providers to use my PHI to make disclosures of PHI to Tarsus for the following purposes:

- Reimbursement support associated with the filling of my prescription for XDEMVY® (lotilaner ophthalmic solution) 0.25%, including the performance of an insurance verification and assisting in securing of any insurance coverage for XDEMVY to which I am entitled.
- Facilitating the provision of patient assistance, reduced cost medication and/or other XDEMVY-related services offered by Tarsus.
- Receiving marketing and promotional communications related to my disease condition, *Demodex* blepharitis, and other information from Tarsus via the contact information I have provided.

With respect to any disclosures by my pharmacies, I understand that my pharmacies will receive remuneration (payment) from Tarsus for making disclosures of PHI and/or support services to Tarsus.

I understand that once my PHI is disclosed under this authorization, it is no longer protected by Federal privacy laws, including HIPAA, and may be further disclosed by Tarsus.

I understand that I may refuse to sign this authorization and that treatment, payment, or eligibility for benefits is not conditioned on my signing this authorization.

I understand that this authorization is valid for a period of 10 years or for a shorter period dictated by applicable state law.

I understand that I may cancel (revoke) this authorization at any time by mailing a letter requesting such cancellation to Tarsus Connect at 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560, but that this cancellation will not apply to any information already used or disclosed through this authorization before notice of the cancellation is received by my Providers.

Name (please print) _____

Signature _____

Describe Relationship to Patient and Authority to Sign If Not the Patient _____

_____ Date____/____/____

tarsus