EyeRx Direct® Enrollment

Théa let's open our eyes

EYERx DIRECT

PATIENT INFORMATION

Name: _____ (First / Middle / Last)

Date of Birth: ___ / ___ / ___ (MM / DD / YYYY) Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Telephone: _____

Best Contact Time: ◯ Morning ◯ Afternoon ◯ Evening

PLEASE CHECK ANY HEALTH CONDITIONS YOU HAVE:

- ◯ Asthma
- ◯ Bleeding
- ◯ Chronic Obstructive Pulmonary Disease (COPD)
- ◯ Depression
- ◯ Diabetes
- ◯ GERD/Ulcer
- ◯ High Cholesterol/Heart Disease
- ◯ Hypertension
- ◯ Liver Disease
- ◯ Renal Disease
- ◯ No Known Health Condition
- ◯ Other (please specify) _____

PLEASE CHECK ALL ALLERGIES YOU HAVE:

- ◯ Amoxicilli
- ◯ Aspirin
- ◯ Cephalosporin
- ◯ Codeine
- ◯ Erythromycin
- ◯ Iodine
- ◯ Penicillin
- ◯ Sulfa
- ◯ Tetracycline
- ◯ No Known Drug Allergy
- ◯ Other (please specify) _____

MEDICATION PRESCRIBED BY EYE DOCTOR (PLEASE CHECK):

◯ Zioptan® ◯ Cosopt® PF ◯ Betimol® ◯ AzaSite®

PHYSICIAN INFORMATION

Physician Name: _____ (First / Last)

Telephone: _____ Fax: _____

PRESCRIPTION INSURANCE INFORMATION (IF AVAILABLE)

◯ Commercial (Private) ◯ Medicare Part D ◯ Medicare ◯ Other _____

Primary Insurance Name: _____

Benefit Identification # (Rx BIN): _____

Insurer ID #: _____

Processor Control # (PCN): _____

Group Name: _____

Group #: _____

TO COMPLETE ENROLLMENT IN THEA EYERX DIRECT, PLEASE CHECK YES OR NO FOR EACH OF THE FOLLOWING:

◯ Yes ◯ No I grant permission for Eagle Pharmacy to contact me for payment card information in order to process payment in advance of shipping my medication. I understand this is a requirement to receive my medication.

◯ Yes ◯ No I understand the information I provide to Eagle Pharmacy is exclusively for purposes related to the Thea EyeRx Direct program, including verification with insurers, and may be communicated to the Centers for Medicare & Medicaid Services.

◯ Yes ◯ No I would like to receive information about the Thea EyeRx Direct program and/or products.

Mail to:
Thea EyeRx Direct
c/o Eagle Pharmacy
PO Box 90937
Lakeland, FL 33804

or

Fax to:
855-618-4610

or

Online:
www.EyeRxDirect.com

Learn More at www.EyeRxDirect.com

Please report negative side effects of prescription drugs to the Food and Drug Administration (FDA) by calling 1-800-FDA-1088 or by visiting www.FDA.gov/MedWatch

Prescription Cost for Patient

This is a home delivery pharmacy program that offers set pricing for your eye medicine shown on this page. This price may or may not be lower than your insurance copay at a retail pharmacy. We encourage you to check the cost at your local pharmacy and compare.

	30-Day Supply	90-Day Supply
ZIOPTAN® (tafluprost ophthalmic solution) 0.0015%	**$60** 1 carton of 30 single use containers	**$150** 3 cartons of 30 single use containers
BETIMOL® (timolol ophthalmic solution) 0.25%, 0.5%	**$60** 1 - 5 mL bottle	**$150** 3 - 5 mL bottle
CosoptPF® (dorzolamide HCl - timolol maleate ophthalmic solution) 2% / 0.5%	**$60** 1 carton of 60 single use containers	**$150** 3 cartons of 60 single use containers
AzaSite® (azithromycin ophthalmic solution) 1%	**$60** 1 - 5 mL bottle	

SCAN ME

Sign up online through www.EyeRxDirect.com or complete enrollment form on back side.

Questions: 844-813-3864 (Monday - Friday, 8:00am - 10:00pm ET)

Health Care Provider Prescribing Options

ePrescribe to:

Eagle Pharmacy
Lakeland, FL 33810

NPI: 1487905840
NCPDP: 5711975

This price may or may not be lower than your copay at your local pharmacy.

or

Fax Prescription to:

Eagle Pharmacy
855-618-4610

or

Mail Prescription to:

Thea EyeRx Direct
c/o Eagle Pharmacy
PO Box 90937
Lakeland, FL 33804

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