EpioxaCareConnect™

Epioxa™ Patient Enrollment Form (PEF) Guide

Three easy steps to initiate the patient enrollment process for Epioxa

1. **STEP 1:** Fill out all fields on the Patient Enrollment Form, including signatures.

To ensure legibility and timely processing, please type all applicable fields. Handwritten entries may delay processing.

2. **STEP 2:** Obtain patient consent ("I consent" check box + patient signature).

3. **STEP 3:** Fax the PEF and consent form along with the front and back of the patient's insurance card(s).

HOW TO SUBMIT

Submit the completed PEF to EpioxaCareConnect via:

Fax: 1-800-839-6276

If you have any questions while completing the form, please contact EpioxaCareConnect at 1-855-5-EPIOXA (1-855-537-4692).

Please see Important Safety Information at the end of this guide, or click here for full Prescribing Information.

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Epioxa™
(riboflavin 5'-phosphate ophthalmic solution)

Patient Information

- Provide the patient's demographic and contact information, including email address
- Indicate whether treatment has been scheduled, denote date and laterality of procedure
- If the patient is under 18, please complete for legally authorized representative

Insurance Information

- Provide the patient's primary insurance information
- Include secondary insurance if applicable, to ensure the accuracy of the benefits investigation

Please attach an image of both sides of the patient's insurance card with your PEF submission

Household Income

(Optional for Patient Assistance Program)

- If known, please provide household income

Site of Care

- Provide site of care information: Facility NPI, Tax ID, and place of service (POS) codes

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For Support call: 1-855-5-EPIOXA M-F, 8am-8pm ET
Fax the completed form to: 1-800-839-6276
www.Epioxa.com

Patient Enrollment Form

(to be completed by provider)

Patient Information

First Name: Jane	Middle Initial:	Last Name: Patient
Date of Birth: 01/17/2009		Gender: ■ F ☐ M ☐ U
Physical Address: 1234 Main Street		
City: Aliso Viejo	State: CA	Zip Code: 92656
Email: janepatient@email.com		Phone Number: 555-123-1234
Preferred Language: English		
Legally Authorized Representative (*required if under 18):		
First Name: Mother	Middle Initial:	Last Name: Patient
Date of Birth: 02/28/1975		
Physical Address: 1234 Main Street		
City: Aliso Viejo	State: CA	Zip Code: 92656
Email: motherpatient@email.com		Phone Number: 555-123-4321

Has treatment been scheduled? Yes ▪ No
Treatment Date(s): Left: DD/MM/YYYY Right: _____ Both: _____
Optional: Faxing chart notes supports the Prior Authorization process.

Insurance Information (Attach both sides of insurance cards)

■ Commercial ☐ Medicaid ☐ Medicare ☐ Other ☐ Uninsured

Primary Insurance: Insurance Provider 1	Secondary/Prescription Drug Insurance: Insurance Provider 2
Policy ID #: 123456	Policy ID #: 987654
Group #: 5555	Group #: 5555
Policyholder First and Last Name: Mother Patient	Policyholder First and Last Name: Mother Patient
Insurance Phone: 800-123-4567	Insurance Phone: 800-123-4567
Policyholder Date of Birth: 02/28/1975	Policyholder Date of Birth: 02/28/1975

Household Income if Applying for Patient Assistance Program (For U.S. Residents Only)

Total Household Income $ _____	Number of household members (including patient) _____

Site of Care

Name of Facility: ClearView Opthalmology Center		
Address of Facility: 1234 Transforming Vision Way		
City: Aliso Viejo	State: CA	Zip Code: 92656
Facility Phone: 949-123-4567	Facility Fax: 949-321-9876	
NPI #: 0000000000	Facility Tax ID #: 123456	
Place of Service (POS) Codes:	■ POS 11- Office ☐ POS 19- Off Campus- Outpatient Hospital: ☐ POS 22- On Campus- Outpatient Hospital ☐ POS 24- Ambulatory Surgical Center ☐ Other	

Prescriber Information

First Name: John	Last Name: Prescriber	
Physical Address: 1234 Transforming Vision Way		
City: Aliso Viejo	State: CA	Zip Code: 92656
NPI #: 0000000000	Tax ID #: 123456	State License #: 00-000000
Clinic/Hospital Affiliation: ClearView Hospital		
Office Contact Name: John Biller		
Office Phone: 949-123-4567	Office Fax: 949-987-6543	
Office Email: KC@clearview.com		
Preferred method of communication: ■ Email ☐ Phone ☐ Fax		
Prescriber Specialty: Opthalmology		

Prescription Information:
EPIOXA™ HD (riboflavin 5′-phosphate ophthalmic solution) 0.239% and EPIOXA™ (riboflavin 5′-phosphate ophthalmic solution) 0.177%

*ICD-10 Diagnosis Code: Check all that apply to the treated eye(s)

☐ H18.60X: Keratoconus, unspecified
☐ H18.61X: Keratoconus, stable
■ H18.62X: Keratoconus, unstable ☐ Other

Quantity: ■ Right Eye/1 box ☐ Left Eye/1 box ☐ Bilateral/2 boxes *Refills: None*

Directions: *Apply the Epioxa HD drop regimen followed by the Epioxa drop regimen topically to the affected eye(s) as directed.*

Prescriber Signature: *John Prescriber* Date: MM/DD/YYYY
(Dispense as written (No Stamps))

Prescriber Signature: _____ Date: _____
Substitution allowed (No Stamps)

The prescriber is to comply with state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. ATTN: NEW YORK AND IOWA PROVIDERS, PLEASE SUBMIT ELECTRONIC PRESCRIPTION.

Has the patient received prior treatment for condition above?
☐ Yes ■ No If so, what treatment? _____

Preferred Drug Acquisition

Buy & Bill: ☐ Specialty Pharmacy: ■

Prescriber Attestation:
By checking the box below, I agree that Glaukos Corporation, its affiliates, agents, representatives, collaborators and service providers (collectively "Glaukos") can use the patient-related information provided for the purposes stated herein. I further certify that the patient is aware of and has expressly consented to and directed the disclosure of their information, which may include Personal Health Information, to Glaukos to enable Glaukos to conduct an insurance coverage investigation and provide insurance reimbursement services related to Epioxa throughout the duration of the patient's treatment and follow-up. My signature certifies that the person named on this form is my patient; that the information provided on this application, to the best of my knowledge, is complete and accurate; and that therapy with Epioxa is medically necessary.

Prescriber Signature: *John Prescriber* Date: MM/DD/YYYY

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PM-US-3306 V2.0 12/2025

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Prescriber Information

- Provide the prescriber's name, office location, NPI, Tax ID, and state license numbers which are required for processing
- Also provide office contact information and preferred method of communication

Prescription Information

- Check box to confirm diagnosis code
- Add quantity

Prescriber signature is required for prescription to be valid. Please select dispense option that applies and provide a wet signature

Prescriber Attestation

- Prescriber/healthcare provider signature is required for processing the Patient Enrollment Form

Disclaimer: The information provided on this form is for demonstration purposes only and does not represent any real person.

Please see Important Safety Information at the end of this guide, or click here for Full Prescribing Information.

Patient Consent and Authorization

Patient must check first REQUIRED box to enroll in EpioxaCareConnect program

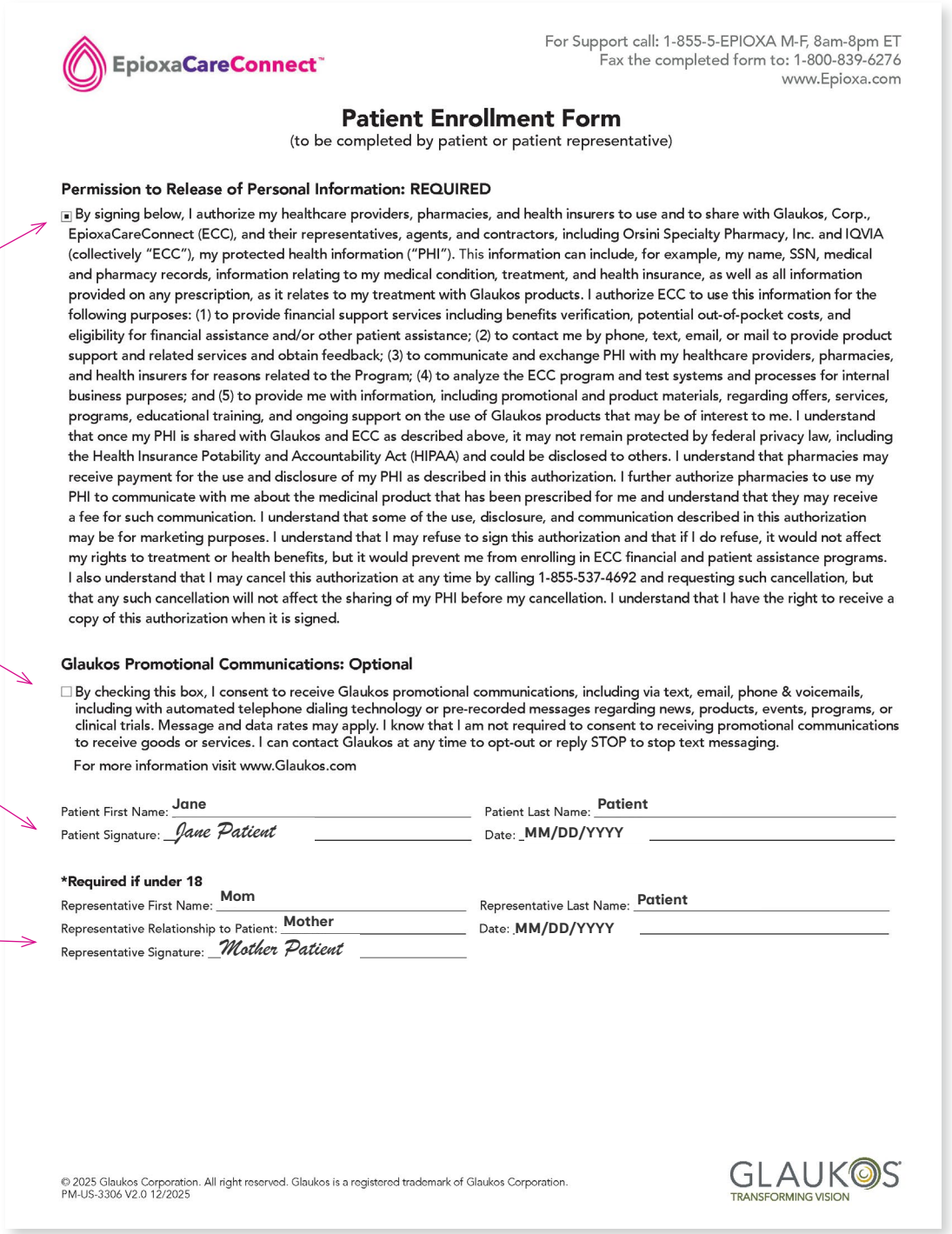
Second box is OPTIONAL to provide consent for Glaukos promotional communications

Patient must sign and date form

If the patient cannot sign the form at your office, a text consent may be sent via EpioxaCareConnect

Required if under 18

- Complete this section if patient is under 18 or would like to add another representative to the enrollment (e.g., a parent or other caregiver).



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Patient Enrollment Form

(to be completed by patient or patient representative)

Permission to Release of Personal Information: REQUIRED

☑ By signing below, I authorize my healthcare providers, pharmacies, and health insurers to use and to share with Glaukos, Corp., EpioxaCareConnect (ECC), and their representatives, agents, and contractors, including Orsini Specialty Pharmacy, Inc. and IQVIA (collectively "ECC"), my protected health information ("PHI"). This information can include, for example, my name, SSN, medical and pharmacy records, information relating to my medical condition, treatment, and health insurance, as well as all information provided on any prescription, as it relates to my treatment with Glaukos products. I authorize ECC to use this information for the following purposes: (1) to provide financial support services including benefits verification, potential out-of-pocket costs, and eligibility for financial assistance and/or other patient assistance; (2) to contact me by phone, text, email, or mail to provide product support and related services and obtain feedback; (3) to communicate and exchange PHI with my healthcare providers, pharmacies, and health insurers for reasons related to the Program; (4) to analyze the ECC program and test systems and processes for internal business purposes; and (5) to provide me with information, including promotional and product materials, regarding offers, services, programs, educational training, and ongoing support on the use of Glaukos products that may be of interest to me. I understand that once my PHI is shared with Glaukos and ECC as described above, it may not remain protected by federal privacy law, including the Health Insurance Potability and Accountability Act (HIPAA) and could be disclosed to others. I understand that pharmacies may receive payment for the use and disclosure of my PHI as described in this authorization. I further authorize pharmacies to use my PHI to communicate with me about the medicinal product that has been prescribed for me and understand that they may receive a fee for such communication. I understand that some of the use, disclosure, and communication described in this authorization may be for marketing purposes. I understand that I may refuse to sign this authorization and that if I do refuse, it would not affect my rights to treatment or health benefits, but it would prevent me from enrolling in ECC financial and patient assistance programs. I also understand that I may cancel this authorization at any time by calling 1-855-537-4692 and requesting such cancellation, but that any such cancellation will not affect the sharing of my PHI before my cancellation. I understand that I have the right to receive a copy of this authorization when it is signed.

Glaukos Promotional Communications: Optional

☐ By checking this box, I consent to receive Glaukos promotional communications, including via text, email, phone & voicemails, including with automated telephone dialing technology or pre-recorded messages regarding news, products, events, programs, or clinical trials. Message and data rates may apply. I know that I am not required to consent to receiving promotional communications to receive goods or services. I can contact Glaukos at any time to opt-out or reply STOP to stop text messaging.

For more information visit www.Glaukos.com

Patient First Name: Jane _____ Patient Last Name: Patient _____

Patient Signature: *Jane Patient* _____ Date: MM/DD/YYYY _____

***Required if under 18**

Representative First Name: Mom _____ Representative Last Name: Patient _____

Representative Relationship to Patient: Mother _____ Date: MM/DD/YYYY _____

Representative Signature: *Mother Patient* _____

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EpioxaCareConnect™

Indication and Important Safety Information

INDICATIONS AND USAGE
EPIOXA™ HD (riboflavin 5'-phosphate ophthalmic solution) 0.239% and EPIOXA™ (riboflavin 5'-phosphate ophthalmic solution) 0.177% are photoenhancers indicated for use in epithelium-on corneal collagen cross-linking for the treatment of keratoconus in adults and pediatric patients aged 13 years and older, in conjunction with the O_2n™ System and the Boost Goggles®.

IMPORTANT SAFETY INFORMATION

Contraindications
EPIOXA™ HD and EPIOXA™ are contraindicated in patients with known hypersensitivity to benzalkonium chloride (BAC) or any ingredients in EPIOXA HD and EPIOXA. Epithelium-on corneal collagen cross-linking is contraindicated in aphakic and pseudophakic patients without a UV-blocking intraocular lens.

Warnings and Precautions
Corneal collagen cross-linking should be used with caution in patients with a history of herpetic keratitis due to the potential for reactivation of herpes keratitis.

Adverse Reactions
The most common adverse reaction was conjunctival hyperaemia (31%). Other adverse reactions, occurring in 5% to 25% of eyes included: corneal opacity (haze), photophobia, punctate keratitis, eye pain, eye irritation, increased lacrimation, corneal epithelium defect, eyelid oedema, corneal striae, visual acuity reduced, dry eye, and anterior chamber flare.

Dosage and Administration
EPIOXA HD and EPIOXA are for topical ophthalmic use. NOT for injection or intraocular use.
EPIOXA HD and EPIOXA are supplied in single-dose syringes. Discard opened syringes after use.
EPIOXA HD and EPIOXA are for use with the O_2n System and Boost Goggles only.
Refer to the O_2n System Operator's Manual and Boost Goggles User Guide for device instructions.

Please see full Prescribing Information for EPIOXA HD and EPIOXA at www.Epioxa.com.
You are encouraged to report all side effects to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088. You may also call Glaukos at 1-888-404-1644.

Disclaimer: Glaukos provides this guide for informational purposes only, and it is subject to change without notice. This guide is intended to provide general information regarding patient enrollment in the EpioxaCareConnect program. It is not intended to provide instruction on billing, coding, coverage, or payment, nor should it be interpreted as a guarantee of reimbursement or payer coverage. It is the responsibility of providers, physicians, facilities, and suppliers to determine appropriate processes for purchasing, inventory management, and product use in accordance with their institutional policies and applicable payer requirements. Providers and facilities should contact their distributors, specialty pharmacies, or third-party payers, as applicable, for current information regarding ordering processes, product availability, and coverage policies. For further detailed product information, including indications for use, contraindications, effects, precautions, and warnings, please consult the product's Instructions for Use (IFU) or prescribing information (PI) prior to use. The information provided herein is without any other warranty or guarantee of any kind, expressed or implied, as to completeness, accuracy, or otherwise.

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NPM-US-0125 V-1 Last updated: May 2026

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Epioxa™
(riboflavin 5'- phosphate ophthalmic solution)