arch
We'll see you through™

Patient Authorization Form

Patient Information

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ Date of Birth: _____

State: _____ Zip: _____ SS# (optional): _____

The ARCH Program is Your Dedicated Resource and Support Team for Photrexa/Photrexa Viscous Access and Reimbursement. We are here to help you understand your benefits for Photrexa/Photrexa Viscous and find comprehensive solutions throughout the reimbursement process—from Benefit Verification through Patient Assistance.

Physician Name: _____ _____
Last Name (Print) First Name (Print)

Office Contact: _____ _____
Full Name (Print) Office Phone

By signing below, I authorize my health care providers, pharmacies, and health insurers to share with Avedro, Inc. and its representatives, agents, and contractors my protected health information ("PHI"), including but not limited to my name, ss# (if provided), 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 Avedro products for purposes of providing the services offered by the ARCH Program; including without limitation (1) financial support services, including benefits verification, potential out-of-pocket costs, and eligibility for financial assistance and/or other patient assistance; (2) providing me with product support and services; (3) communicate and exchange PHI with my health care providers, pharmacies, and health insurers for reasons related to the Program; (4) internal business purposes such as testing systems and processes; and (5) contacting me by mail, e-mail, text, telephone, or any other alternative communication method I authorize. I understand that once my PHI is shared with Avedro as described above, it may not remain protected by federal privacy law. 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 from my insurance for such communication.

I understand that I may refuse to sign this authorization and that if I do refuse, that it would not affect my rights to treatment or health benefits, but it would prevent me from enrolling in the ARCH Program. I also understand that I may cancel this authorization at any time by writing to ARCH, 201 Jones Road, 5th Floor, Waltham, MA 02451, **1-844-528-3311**, and requesting such cancellation, but that any such cancellation will not affect the sharing of my PHI before my cancellation. If I do not cancel this authorization earlier, it will remain valid for 10 years from the date of my signature below. I understand that I have a right to receive a copy of this authorization when it is signed.

_____ _____
Patient or Representative Name (Print) Patient or Rep Signature

_____
Relationship to the Patient, including the authority for status as Personal Representative

_____
Date