

JETREA® (ocriplasmin) injection, for Intravitreal Injection, 1.25 mg/mL

Patient Assistance Program (PAP) – Rendered Uninsured

Attestation of Denied Coverage

This form will serve as proof and evidence that the patient’s insurance plan will not cover JETREA for an FDA-approved indication. A PAP request cannot be considered until a first-level appeal has been denied. A separate form is required for each of the patient’s subsequent insurances.

Please fax this completed form to JETREA CARE® at 1-855-362-0729

Physician’s Statement of Accurate Representation (REQUIRED)

Patient Name (Please Print): _____

Patient Date of Birth: _____ Date of Service: _____

Insurance Company / Plan: _____

Physician Name (Please Print): _____

Physician Signature (Required): _____ Date: _____

Attestation: My signature above certifies that the provided information is an accurate representation of my patient’s insurance company’s denial of coverage for JETREA. If requested, I will provide any and all necessary documentation of denials / appeals in a timely fashion.

___ Prior Authorization

Date of initial denial: ____/____/____ Reason: _____

Date of appeal denial: ____/____/____ Reason: _____

___ Claim Denial

Date of initial denial: ____/____/____ Reason: _____

Date of appeal denial: ____/____/____ Reason: _____

___ Peer-to-Peer Denial

Date of Review: ____/____/____ Reason: _____

___ Payer Recoupment

Date of Request: ____/____/____ Reason: _____

PLEASE NOTE: *If a patient is denied insurance coverage as a result of not adhering to a payer’s medical policy guidelines for JETREA, an administrative claim error, or an untimely claim filing, your request does not meet the eligibility criteria for PAP.*

For information on PAP, its eligibility criteria, or process, please contact JETREA CARE® at 1-855-879-5387.

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