# CystaTouch™

## COMFORT DROPPER

for use with CYSTADROPS

**FREE TRIAL PROGRAM**

**Fax the attached documents to Anovo Specialty Pharmacy to receive a no-cost* 14-day trial of CYSTADROPS with the new CYSTATOUCH COMFORT DROPPER.**

**Anovo Specialty Pharmacy Fax (855-813-2039)**

*TRIAL VOUCHER PROGRAM ELIGIBILTY FOR FIRST TIME USERS OF CYSTADROPS OR THE REDESIGNED CYSTATOUCH DROPPER WITH A NEW CYSTADROPS PRESCRIPTION.

**Please see full Prescribing Information and Instructions for Use at www.CYSTADROPS.com/PI.**

CYSTADROPS is a licensed trademark of Recordati Rare Diseases Inc.
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www.recordatirarediseases.com/us PP-CDPS-US-0219

# PATIENT AGREEMENT

I authorize Anovo Specialty Pharmacy to dispense a no-cost one time, 14-day supply of CYSTADROPS. There is no purchase obligation to participate in the Voucher Program. This program is optional. Participation is subject to eligibility and the CYSTADROPS Voucher Program Patient Agreement and Terms and Conditions listed below, which are subject to change.

**By redeeming this voucher, I (as the patient) acknowledge and agree that I (i) to the best of my knowledge, meet the eligibility criteria and (ii) will comply with the CYSTADROPS Voucher Program terms and conditions set forth herein.**

I hereby authorize my health care provider and pharmacy to disclose my personal and health information which may include my name, address, phone number, date of birth, medical history, prescriptions and health insurance information to Recordati Rare Diseases, Inc., the manufacturer of CYSTADROPS and the provider of the CYSTADROPS Voucher Program, and its agents (collectively "Recordati") in connection with the CYSTADROPS Voucher Program and in accordance with applicable privacy laws. I understand that the support provided through this program is not contingent on any further purchase or use of Recordati products.

### Authorized Purposes

I authorize and agree to the use of my health and personal information by Recordati to: (1) determine my eligibility for the CYSTADROPS Voucher Program and (2) administer the program to me and dispense my 14-day supply of product if my participation is approved.

### Expiration of Authorization

My authorization shall expire one (1) year from the date of signature unless revoked sooner.

### Acknowledgements

1. I understand that once Recordati receives my information, my medical information may be subject to re-disclosure and will no longer be protected by federal privacy laws.
2. I understand that signing this authorization is voluntary, and that I may refuse to sign this authorization form. My refusal to sign this authorization will not affect my ability to obtain health plan benefits or treatment from my provider. However, I understand that I will not be eligible for the CYSTADROPS Voucher Program.
3. I understand that I may revoke my authorization at any time by providing written notice to info@recordatirarediseases.com. However, I understand that if I revoke this authorization, it will not affect prior disclosures made under this authorization.
4. I understand that completing this form does not guarantee that I will qualify for the CYSTADROPS Voucher Program.
5. I understand that Recordati reserves the right to change or cancel the CYSTADROPS Voucher Program at any time.
6. I understand that as a condition of participating in the program, I cannot seek any reimbursement or otherwise seek to apply the value of the no cost product to any deductible or other out of pocket cost limits under my health plan or government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP). I agree that I will not submit (or cause to be submitted) any claim for product I receive thru the CYSTADROPS Voucher Program to any third party payer, including Medicaid, Medicare other federal or state program.
7. I understand and agree that I must comply with the terms of my health insurance contract, if any, and shall (if required) provide notice of the existence and/or value of this voucher.
8. I certify that I have not previously received a free sample of CYSTADROPS®.

# PATIENT AGREEMENT

**Program Terms & Conditions**

The patient, or health care provider on the patient's behalf, must provide a completed enrollment form and a valid prescription for the CYSTADROPS® Voucher Program. Patients have no obligation to continue to use CYSTADROPS® after the program ends. **This voucher is only accepted at Anovo Specialty Pharmacy**.

Offer valid in the United States and Puerto Rico, and void where prohibited by law. Not valid in Massachusetts or Vermont. This voucher may be rescinded, revoked or amended at any time without notice. Voucher expires on December 31, 2025.

This trial voucher is not health insurance. This voucher is not intended to address delays or gaps in health insurance coverage for the specified prescription.

This voucher cannot be combined with any other savings, rebate coupon, no cost trial, no cost sample or other similar offer for the specified prescription.

It is illegal to sell, purchase, or trade this voucher card (or to offer to do so).

Eligibility Criteria: This voucher is limited to one redemption per patient. This voucher is for first time users of CYSTADROPS or the redesigned CystaTouch Dropper with a new CYSTADROPS prescription. CYSTADROPS has been redesigned with the new CystaTouch dropper (available in the US on February 1, 2025) to make medication administration easier. Must be 18 years of age or older to redeem this voucher. For patients under 18 years of age, the voucher may only be redeemed by the patient's parent, or a guardian over 18 years of age.

Patient/Guardian Signature: ______________________

If Guardian, relationship to patient: ______________________

Date: ______________

# PRESCRIPTION ORDER

**CYSTADROPS®**
**(cysteamine ophthalmic solution) 0.37%**
**Prescription Order Form**

**Fax: 855-813-2039**
**Phone: 866-925-6212**

**Please select one:** ☐ **Newly Prescribed Patient**

**Patient Information** *Please print*

| | | | |
|---|---|---|---|
| Last Name: First Name: | SSN: | | Sex: ◯M ◯F |
| Address: | City: | State: | Zip: |
| Phone: Day # | Evening #: | Cell # : | |
| DOB: | | | |
| If Patient is a Minor, Guardian/Parent Name: | Relation to Patient: | | |
| Emergency Contact: | Phone #: | | |

**Insurance Information** *Include copies of insurance cards

| | | |
|---|---|---|
| Primary Insurance Co. Name: | | Phone #: |
| Policy Holder Name: | Policy #: | Group #: |
| Prescription Card Name: | | Phone #: |
| Policy #: | | Group #: |
| Secondary Insurance Co. Name: | | Phone #: |
| Policy Holder Name: | Policy #: | Group #: |

**Physician Information**

| | | |
|---|---|---|
| Prescriber Name/Title: | | |
| NPI: DEA: Medicaid UPIN: | | State License #: |
| Address: | | |
| City: | State: Zip: | |
| Name of Contact Person: | | Phone: |
| Physician Email: | | Fax: |

**Prescription**

**CYSTADROPS® (cysteamine ophthalmic solution) 0.37%**

Sig: _____ drop(s) in each eye four times a day. Do not touch dropper to eye. Discard unused portion after 7 days.

PLEASE NOTE: Minimum dispense is 1 shipment containing 4 bottles of Cystadrops

Dispense ☐ 1-month supply (4 bottles) ☐ 3-month supply (12 bottles)

**Refills** __________

**Medical Necess**

| | | |
|---|---|---|
| Primary diagnosis: | Date of Diagnosis : | Patient Age at Diagnosis: |

Please check applicable ICD-10 code:

☐ Cystinosis (E72.04)

Therapy Start Date:

Allergies ☐ NKDA

**I certify I am prescribing CYSTADROPS® for this patient for a medically necessary purpose.** **Date Written:** ____________________

**Dispense as Written:**____________________
(Stamped Signatures Are Not Valid)

**Substitution Allowed:** ____________________
(Stamped Signatures Are Not Valid)

**This Prescription Form is only valid if FAXED to Anovo @ 855-813-2039**

Form:CYSDP.Voucher.RX.01
Effective Date: 2/10/2025
Revision Date: