



# Acthar<sup>®</sup> GEL

(repository corticotropin injection) 80 U/mL

SENT PRESCRIPTION DIRECTLY TO SPECIALTY PHARMACY.  
PLEASE ENROLL PATIENT IN ACTHAR PATIENT SUPPORT.

PHARMACY NAME: \_\_\_\_\_

**FAX: 1-877-937-2284**

**Acthar Referral Form**

Please complete Referral Form and fax toll-free

TEL: 1-888-435-2284

Monday through Friday (8:00 AM to 9:00 PM ET)

Saturday (9:00 AM to 2:00 PM ET)

**1. PATIENT INFORMATION** Patient has been notified of referral  YES  NO

PATIENT FIRST NAME	PATIENT MIDDLE INITIAL	PATIENT LAST NAME	DATE OF BIRTH	GENDER
HOME ADDRESS	CITY		STATE	ZIP
SHIPPING ADDRESS (IF NOT HOME ADDRESS)	CARE OF (IF NOT ADDRESSED TO PATIENT)	CITY	STATE	ZIP
HOME PHONE	MOBILE	<input type="checkbox"/> OK TO TEXT	BEST TIME TO CALL	
EMAIL ADDRESS	PREFERRED LANGUAGE IF NOT ENGLISH			
ALTERNATIVE CONTACT NAME	TELEPHONE	<input type="checkbox"/> VOICEMAIL APPROVAL	EMAIL	RELATIONSHIP TO PATIENT

**2. INSURANCE INFORMATION** (Please include copies of front and back of all medical and prescription insurance cards)

PHARMACY BENEFITS	SUBSCRIBER ID #	GROUP #	TEL #
PRIMARY MEDICAL INSURANCE	SUBSCRIBER ID #	GROUP #	TEL #

**3. PRESCRIBER INFORMATION**

PRESCRIBER FIRST NAME	PRESCRIBER MIDDLE INITIAL	PRESCRIBER LAST NAME	NPI #	GROUP NPI # (IF APPLICABLE)	STATE LICENSE #
SPECIALTY: <input type="checkbox"/> OPHTHALMOLOGY <input type="checkbox"/> OTHER (PLEASE INDICATE) _____					
FACILITY NAME	TELEPHONE	FAX			
ADDRESS	CITY	STATE	ZIP		
OFFICE CONTACT NAME	CONTACT TELEPHONE	MOBILE NUMBER	CONTACT EMAIL ADDRESS		
PREFERRED METHOD OF COMMUNICATION: <input type="checkbox"/> OFFICE PHONE <input type="checkbox"/> MOBILE PHONE <input type="checkbox"/> FAX <input type="checkbox"/> EMAIL <input type="checkbox"/> TEXT <input type="checkbox"/> NO PREFERENCE PREFERRED CONTACT TIME: _____					

**4. PRESCRIPTION: ACTHAR<sup>®</sup> GEL** NDC# 63004-8710-1 5 mL multidose vial containing 80 USP units per mL

**4A. PLEASE SELECT AN FDA-APPROVED RECOMMENDED DOSE OR OTHER DOSE**

40 UNITS, 2 TIMES A WEEK  80 UNITS, 2 TIMES A WEEK

OTHER DOSE: \_\_\_\_\_  UNITS  mL

SCHEDULE/FREQUENCY: \_\_\_\_\_

ROUTE OF ADMINISTRATION:  INTRAMUSCULAR  SUBCUTANEOUS

QUANTITY OF 5 mL MULTIDOSE VIALS: \_\_\_\_\_ REFILLS: \_\_\_\_\_

**4B. TAPER INSTRUCTIONS**  See attached taper schedule for Additional Taper Instructions  
ADDITIONAL SPECIAL INSTRUCTIONS, TITRATION OR TAPER DOSE, IF APPLICABLE:

**4C. ALLERGIES**

PLEASE PROVIDE ALLERGY INFORMATION, IF APPLICABLE (Additional space provided on page 2):

**4D. ICD-10 CODE:** \_\_\_\_\_

PRIMARY DIAGNOSIS CODES CAN BE FOUND ON PAGE 2, SECTION 6. FOR A FULL LIST OF DIAGNOSIS CODES, PLEASE SEE APPENDIX - PAGES (i) THROUGH (ii) (NOT AN EXHAUSTIVE LIST)

**4E. IDENTIFYING SUPPLIES IS MANDATORY FOR A COMPLETE PRESCRIPTION**

**SYRINGE SIZE:** QUANTITY:  
 1 mL  3 mL  Other: \_\_\_\_\_ TOTAL: \_\_\_\_\_

**NEEDLE SIZE FOR DRAWING:** QUANTITY:  
 20 G needle, 1"  Other: \_\_\_\_\_ TOTAL: \_\_\_\_\_

**NEEDLE SIZE FOR INJECTION:** QUANTITY:  
 23 G needle, 5/8"  23 G needle, 3/4"  
 23 G needle, 1"  Other: \_\_\_\_\_ TOTAL: \_\_\_\_\_

SUPPLY REFILLS: \_\_\_\_\_ SHARPS CONTAINER: \_\_\_\_\_

**5. PRESCRIPTION, CONSENT, AND STATEMENT OF MEDICAL NECESSITY: PRESCRIBER SIGNATURE REQUIRED**

**ACTHAR INJECTION TRAINING SERVICES**

By checking here, I request that company-funded Acthar Injection Training Services be arranged for my patient. I understand that Acthar Injection Training Services are available for multiple visits but are NOT a home health nursing service. Patients can contact their Nurse Navigator at any time about injection training.

I certify that Acthar<sup>®</sup> Gel is medically necessary for this patient and that I have reviewed this therapy with the patient and will be monitoring the patient's treatment. I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and that the information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to me by the dispensing pharmacy.

I authorize United BioSource LLC ("UBC"), the current operator of Acthar Patient Support, and other designated operators of the Program to perform a preliminary and on-going assessment of benefit verification for this patient and furnish information requested by the patient's insurer that is available on this form. I understand that insurance verification is ultimately the responsibility of the provider and third-party reimbursement is affected by a variety of factors. While UBC tries to provide accurate information, they and Mallinckrodt make no representations or warranties as to the accuracy of the information provided.

I understand that representatives from the Program or UBC may contact me or my patient for additional information relating to this prescription. I acknowledge and agree that this prescription may be sent to and received by the designated Specialty Pharmacy by any means under applicable law, including via a designated third party or other operator of the Program, and that no additional confirmation of receipt of prescription is required by the designated Specialty Pharmacy.

Prescriber authorizes UBC to use the Surescripts network on Prescriber's behalf in connection with this enrollment form. Prescriber will comply with all Surescripts' terms and conditions including confidentiality, commercial messaging, privacy and security, applicable laws, and use of data. All Surescripts disclaimers apply. A full list of terms and conditions is available at [www.ubc.com/surescriptsterms](http://www.ubc.com/surescriptsterms).

**PRESCRIBER SIGNATURE: Please sign only ONE LINE below**

**DISPENSE AS WRITTEN** \_\_\_\_\_ DATE \_\_\_\_\_ **OR**  **SUBSTITUTIONS ALLOWED** \_\_\_\_\_ DATE \_\_\_\_\_

Prescriber signature required for consent and to validate prescriptions. Prescriber attests that this is her/his signature. NO STAMPS.  
By signing, Prescriber certifies that the above is medically necessary.

**6. DIAGNOSIS AND MEDICAL INFORMATION**

**DIAGNOSIS CODES**

Please check all diagnosis codes that correspond with patient's diagnosis. Below is a list of common ICD-10 codes. You may also write in the patient's diagnosis in the "OTHER" section. A full list of diagnosis codes can be found in the Appendix – Pages (i) through (ii).

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> NEUROMYELITIS OPTICA [DEVIC] <b>G36.0</b>                    | <input type="checkbox"/> OTHER KERATOCONJUNCTIVITIS, BILATERAL <b>H16.293</b>     | <input type="checkbox"/> SECONDARY NONINFECTIOUS IRIDOCYCLITIS, RIGHT EYE <b>H20.041</b> | <input type="checkbox"/> PANUVEITIS, LEFT EYE <b>H44.112</b>                 |
| <input type="checkbox"/> UNSPECIFIED SCLERITIS, UNSPECIFIED EYE <b>H15.009</b>        | <input type="checkbox"/> DIFFUSE INTERSTITIAL KERATITIS, RIGHT EYE <b>H16.321</b> | <input type="checkbox"/> CHRONIC IRIDOCYCLITIS, RIGHT EYE <b>H20.11</b>                  | <input type="checkbox"/> PANUVEITIS, BILATERAL <b>H44.113</b>                |
| <input type="checkbox"/> SCLERITIS WITH CORNEAL INVOLVEMENT, RIGHT EYE <b>H15.041</b> | <input type="checkbox"/> DIFFUSE INTERSTITIAL KERATITIS, LEFT EYE <b>H16.322</b>  | <input type="checkbox"/> CHRONIC IRIDOCYCLITIS, LEFT EYE <b>H20.12</b>                   | <input type="checkbox"/> SYMPATHETIC UVEITIS, UNSPECIFIED EYE <b>H44.139</b> |
| <input type="checkbox"/> UNSPECIFIED SUPERFICIAL KERATITIS, BILATERAL <b>H16.103</b>  | <input type="checkbox"/> DIFFUSE INTERSTITIAL KERATITIS, BILATERAL <b>H16.323</b> | <input type="checkbox"/> CHRONIC IRIDOCYCLITIS, BILATERAL <b>H20.13</b>                  | <input type="checkbox"/> RETROBULBAR NEURITIS, RIGHT EYE <b>H46.11</b>       |
| <input type="checkbox"/> FILAMENTARY KERATITIS, BILATERAL <b>H16.123</b>              | <input type="checkbox"/> OTHER KERATITIS <b>H16.8</b>                             | <input type="checkbox"/> UNSPECIFIED IRIDOCYCLITIS <b>H20.9</b>                          | <input type="checkbox"/> RETROBULBAR NEURITIS, LEFT EYE <b>H46.12</b>        |
| <input type="checkbox"/> PUNCTATE KERATITIS, RIGHT EYE <b>H16.141</b>                 | <input type="checkbox"/> PRIMARY IRIDOCYCLITIS, LEFT EYE <b>H20.012</b>           | <input type="checkbox"/> UNSPECIFIED CHORIORETINAL INFLAMMATION, BILATERAL <b>H30.93</b> | <input type="checkbox"/> OTHER OPTIC NEURITIS <b>H46.8</b>                   |
| <input type="checkbox"/> PUNCTATE KERATITIS, LEFT EYE <b>H16.142</b>                  | <input type="checkbox"/> RECURRENT ACUTE IRIDOCYCLITIS, LEFT EYE <b>H20.022</b>   | <input type="checkbox"/> RETINAL VASCULITIS, BILATERAL <b>H35.063</b>                    | <input type="checkbox"/> UNSPECIFIED OPTIC NEURITIS <b>H46.9</b>             |
| <input type="checkbox"/> PUNCTATE KERATITIS, BILATERAL <b>H16.143</b>                 |   | <input type="checkbox"/> PANUVEITIS, RIGHT EYE <b>H44.111</b>                            | <input type="checkbox"/> OTHER:  |

**7. HISTORY OF CORTICOSTEROID USE (IF APPLICABLE) PLEASE ADD DETAILS IN SECTION 9 BELOW.**

PLEASE CHECK ALL THAT APPLY:

A corticosteroid **was** tried with the following response(s):

- Corticosteroid use failed, but same response not expected with Acthar
- Patient hypersensitive or allergic to corticosteroids
- Patient intolerant of corticosteroids
- Other: \_\_\_\_\_

OR

A corticosteroid **was not** tried due to the following response(s):

- Corticosteroid use is contraindicated for this patient
- Intravenous access is not possible for this patient
- Patient has known intolerance to corticosteroids
- Other: \_\_\_\_\_

**8. CONCURRENT MEDICATIONS**

**9. RELEVANT TREATMENT HISTORY (INCLUDING RECENT CORTICOSTEROID HISTORY. ATTACH ADDITIONAL CASE NOTES AS NECESSARY.)**

Therapy Name	Dose	Start Date	Stop Date (if applicable)	Explain Outcome With Detail (eg, type of outcome)

**OTHER RELEVANT CLINICAL INFORMATION (INCLUDING ALLERGIES)**

- NKDA - No known drug allergies

**PRESCRIBER SIGNATURE: REQUIRED FOR DOCUMENTATION**

I verify that the patient and prescriber information on this enrollment form was completed by me or at my direction and that the information contained herein is complete and accurate to the best of my knowledge. I certify that my patient has agreed in writing to be contacted by Program administrators or UBC and be furnished with Program or other information or materials.

NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**10. PATIENT AUTHORIZATION(S)**

**Patient Consent to allow Acthar Patient Support Team to work together with your insurance provider, pharmacy, advocacy organization and others to provide support on your behalf.**

By signing this authorization, I authorize my physician(s), my health insurance company and my pharmacy providers (collectively, "Designated Parties") to disclose to Mallinckrodt ARD LLC ("Mallinckrodt"), the distributor of Acthar, and its agents, authorized designees and contractors, including Mallinckrodt reimbursement support personnel and United BioSource LLC ("UBC") or any other operator of Acthar Patient Support on behalf of Mallinckrodt (collectively, "Manufacturer Parties"), health information relating to my medical condition, treatment and insurance coverage (my "Health Information") in order for them to (1) provide certain services to me, including reimbursement and coverage support, patient assistance and access programs, medication shipment tracking, and home injection training, (2) provide me with support services and information associated with my Acthar therapy, (3) serve internal business purposes, such as marketing research, internal financial reporting and operational purposes, and (4) carry out the Manufacturer Parties' respective legal responsibilities. I further agree and acknowledge that one or more representatives of a Manufacturing Party may participate remotely via video conferencing or similar technology in home injection training and related support services for quality control purposes.

Once my Health Information has been disclosed to Manufacturer Parties, I understand that it may be redisclosed by them and no longer protected by federal and state privacy laws. However, Manufacturer Parties agree to protect my Health Information by using and disclosing it only for the purposes detailed in this authorization or as permitted or required by law.

I understand that I may refuse to sign this authorization and that my physician and pharmacy will not condition my treatment on my agreement to sign this authorization form, and my health plan or health insurance company will not condition payment for my treatment, insurance enrollment or eligibility for insurance benefits on my agreement to sign this authorization form. I understand that my pharmacies and other Designated Parties may receive payment in connection with the disclosure of my Health Information as provided in this authorization. I understand that I am entitled to receive a copy of this authorization after I sign it.

I may revoke (withdraw) this authorization at any time by mailing a letter to Acthar Patient Support, 680 Century Point, Lake Mary, FL 32746. Revoking this authorization will end further disclosure of my Health Information to Manufacturer Parties by my pharmacy, physicians, and health insurance company when they receive a copy of the revocation, but it will not apply to information they have already disclosed to Manufacturer Parties based on this authorization. I also know I may cancel my enrollment in a patient support program at any time in writing by contacting Mallinckrodt via fax at 1-877-937-2284 or by calling Acthar Patient Support at 1-888-435-2284. This authorization is in effect for 5 years unless a shorter period is provided for by state law or until the conclusion of any ongoing coverage support, whichever is longer, once I have signed it unless I cancel it before then.


**THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY, INCLUDING DATE**

 \_\_\_\_\_ **X** \_\_\_\_\_  
PATIENT NAME OR LEGAL REPRESENTATIVE      PATIENT SIGNATURE      IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT      DATE

**Patient Consent to receive additional information from Mallinckrodt such as education on your disease and Acthar.**

I authorize Mallinckrodt and its partners to use, disclose, and/or transfer the personal information I supply (1) to contact me and provide me with informational and marketing materials and clinical trial opportunities related to my condition or treatment by any means of communication, including but not limited to text, email, mail, or telephone; (2) to help Mallinckrodt improve, develop, and evaluate products, services, materials, and programs related to my condition or treatment; (3) to enroll me in and provide me with Acthar-related programs and services that I may select or refuse at any time; (4) to disclose my enrollment and use of these services to my prescriber and insurers; and (5) to use my information that cannot identify me for scientific and market research. This authorization will remain in effect until I cancel it, which I may do at any time in writing by contacting Mallinckrodt via fax at 1-877-937-2284 or by calling Acthar Patient Support at 1-888-435-2284. I may request a copy of this signed authorization.

**THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY, INCLUDING DATE**

 \_\_\_\_\_ **X** \_\_\_\_\_  
PATIENT NAME OR LEGAL REPRESENTATIVE      PATIENT SIGNATURE      IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT      DATE

If patient is not present to sign the form, send them to

**ActharConsent.com**  
and have them sign electronically.

## **IMPORTANT SAFETY INFORMATION**

### **Contraindications**

- Acthar should never be administered intravenously
- Administration of live or live attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of Acthar
- Acthar is contraindicated where congenital infections are suspected in infants
- Acthar is contraindicated in patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, or sensitivity to proteins of porcine origin

### **Warnings and Precautions**

- The adverse effects of Acthar are related primarily to its steroidogenic effects
- Acthar may increase susceptibility to new infection or reactivation of latent infections
- Suppression of the hypothalamic-pituitary-adrenal (HPA) axis may occur following prolonged therapy with the potential for adrenal insufficiency after withdrawal of the medication. Adrenal insufficiency may be minimized by tapering of the dose when discontinuing treatment. During recovery of the adrenal gland patients should be protected from the stress (e.g. trauma or surgery) by the use of corticosteroids. Monitor patients for effects of HPA suppression after stopping treatment
- Cushing's syndrome may occur during therapy but generally resolves after therapy is stopped. Monitor patients for signs and symptoms
- Acthar can cause elevation of blood pressure, salt and water retention, and hypokalemia. Blood pressure, sodium, and potassium levels may need to be monitored
- Acthar often acts by masking symptoms of other diseases/disorders. Monitor patients carefully during and for a period following discontinuation of therapy
- Acthar can cause GI bleeding and gastric ulcer. There is also an increased risk for perforation in patients with certain gastrointestinal disorders. Monitor for signs of bleeding
- Acthar may be associated with central nervous system effects ranging from euphoria, insomnia, irritability, mood swings, personality changes, and severe depression to psychosis. Existing conditions may be aggravated
- Patients with comorbid disease may have that disease worsened. Caution should be used when prescribing Acthar in patients with diabetes and myasthenia gravis
- Prolonged use of Acthar may produce cataracts, glaucoma, and secondary ocular infections. Monitor for signs and symptoms
- Acthar is immunogenic and prolonged administration of Acthar may increase the risk of hypersensitivity reactions. Neutralizing antibodies with chronic administration may lead to loss of endogenous ACTH activity
- There is an enhanced effect in patients with hypothyroidism and in those with cirrhosis of the liver
- Long-term use may have negative effects on growth and physical development in children. Monitor pediatric patients
- Decrease in bone density may occur. Bone density should be monitored for patients on long-term therapy
- Pregnancy Class C: Acthar has been shown to have an embryocidal effect and should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

### **Adverse Reactions**

- Common adverse reactions for Acthar are similar to those of corticosteroids and include fluid retention, alteration in glucose tolerance, elevation in blood pressure, behavioral and mood changes, increased appetite, and weight gain
- Specific adverse reactions reported in IS clinical trials in infants and children under 2 years of age included: infection, hypertension, irritability, Cushingoid symptoms, constipation, diarrhea, vomiting, pyrexia, weight gain, increased appetite, decreased appetite, nasal congestion, acne, rash, and cardiac hypertrophy. Convulsions were also reported, but these may actually be occurring because some IS patients progress to other forms of seizures and IS sometimes masks other seizures, which become visible once the clinical spasms from IS resolve

**Other adverse events reported are included in the full Prescribing Information.**

**Please see accompanying full Prescribing Information for additional Important Safety Information or visit <https://www.acthar.com/pdf/Acthar-PI.pdf>.**

## **INDICATION AND USAGE**

Acthar<sup>®</sup> Gel (repository corticotropin injection) is indicated for severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation.

**RESOURCE PAGE. DO NOT NEED TO FAX BACK.**

**OPHTHALMOLOGY**

- SARCOID IRIDOCYCLITIS  
**D86.83**
- DISCOID LUPUS ERYTHEMATOSUS OF RIGHT UPPER EYELID  
**H01.121**
- DISCOID LUPUS ERYTHEMATOSUS OF RIGHT LOWER EYELID  
**H01.122**
- DISCOID LUPUS ERYTHEMATOSUS OF RIGHT EYE, UNSPECIFIED EYELID  
**H01.123**
- DISCOID LUPUS ERYTHEMATOSUS OF LEFT UPPER EYELID  
**H01.124**
- DISCOID LUPUS ERYTHEMATOSUS OF LEFT LOWER EYELID  
**H01.125**
- DISCOID LUPUS ERYTHEMATOSUS OF LEFT EYE, UNSPECIFIED EYELID  
**H01.126**
- DISCOID LUPUS ERYTHEMATOSUS OF UNSPECIFIED EYE, UNSPECIFIED EYELID  
**H01.129**
- OTHER SPECIFIED INFLAMMATIONS OF EYELID  
**H01.8**
- UNSPECIFIED INFLAMMATION OF EYELID  
**H01.9**
- CHRONIC DACRYOADENITIS, RIGHT LACRIMAL GLAND  
**H04.021**
- CHRONIC DACRYOADENITIS, LEFT LACRIMAL GLAND  
**H04.022**
- CHRONIC DACRYOADENITIS, BILATERAL LACRIMAL GLAND  
**H04.023**
- CHRONIC DACRYOADENITIS, UNSPECIFIED LACRIMAL GLAND  
**H04.029**
- CHRONIC DACRYOCYSTITIS OF RIGHT LACRIMAL PASSAGE  
**H04.411**
- CHRONIC DACRYOCYSTITIS OF LEFT LACRIMAL PASSAGE  
**H04.412**
- CHRONIC DACRYOCYSTITIS OF BILATERAL LACRIMAL PASSAGES  
**H04.413**
- CHRONIC DACRYOCYSTITIS OF UNSPECIFIED LACRIMAL PASSAGE  
**H04.419**
- UNSPECIFIED ACUTE INFLAMMATION OF ORBIT  
**H05.00**
- TENONITIS OF RIGHT ORBIT  
**H05.041**
- TENONITIS OF LEFT ORBIT  
**H05.042**
- TENONITIS OF BILATERAL ORBITS  
**H05.043**
- TENONITIS OF UNSPECIFIED ORBIT  
**H05.049**
- UNSPECIFIED CHRONIC INFLAMMATORY DISORDERS OF ORBIT  
**H05.10**
- GRANULOMA OF RIGHT ORBIT  
**H05.111**
- GRANULOMA OF LEFT ORBIT  
**H05.112**
- GRANULOMA OF BILATERAL ORBITS  
**H05.113**
- GRANULOMA OF UNSPECIFIED ORBIT  
**H05.119**
- ORBITAL MYOSITIS, RIGHT ORBIT  
**H05.121**
- ORBITAL MYOSITIS, LEFT ORBIT  
**H05.122**
- ORBITAL MYOSITIS, BILATERAL  
**H05.123**
- ORBITAL MYOSITIS, UNSPECIFIED ORBIT  
**H05.129**
- ACUTE ATOPIC CONJUNCTIVITIS, RIGHT EYE  
**H10.11**
- ACUTE ATOPIC CONJUNCTIVITIS, LEFT EYE  
**H10.12**
- ACUTE ATOPIC CONJUNCTIVITIS, BILATERAL  
**H10.13**
- UNSPECIFIED CHRONIC CONJUNCTIVITIS, RIGHT EYE  
**H10.401**
- UNSPECIFIED CHRONIC CONJUNCTIVITIS, LEFT EYE  
**H10.402**
- UNSPECIFIED CHRONIC CONJUNCTIVITIS, BILATERAL  
**H10.403**
- UNSPECIFIED CHRONIC CONJUNCTIVITIS, UNSPECIFIED EYE  
**H10.409**
- CHRONIC GIANT PAPILLARY CONJUNCTIVITIS, RIGHT EYE  
**H10.411**
- CHRONIC GIANT PAPILLARY CONJUNCTIVITIS, LEFT EYE  
**H10.412**
- CHRONIC GIANT PAPILLARY CONJUNCTIVITIS, BILATERAL  
**H10.413**
- CHRONIC GIANT PAPILLARY CONJUNCTIVITIS, UNSPECIFIED EYE  
**H10.419**
- SIMPLE CHRONIC CONJUNCTIVITIS, RIGHT EYE  
**H10.421**
- SIMPLE CHRONIC CONJUNCTIVITIS, LEFT EYE  
**H10.422**
- SIMPLE CHRONIC CONJUNCTIVITIS, BILATERAL  
**H10.423**
- SIMPLE CHRONIC CONJUNCTIVITIS, UNSPECIFIED EYE  
**H10.429**
- CHRONIC FOLLICULAR CONJUNCTIVITIS, RIGHT EYE  
**H10.431**
- CHRONIC FOLLICULAR CONJUNCTIVITIS, LEFT EYE  
**H10.432**
- CHRONIC FOLLICULAR CONJUNCTIVITIS, BILATERAL  
**H10.433**
- CHRONIC FOLLICULAR CONJUNCTIVITIS, UNSPECIFIED EYE  
**H10.439**
- VERNAL CONJUNCTIVITIS  
**H10.44**
- OTHER CHRONIC ALLERGIC CONJUNCTIVITIS  
**H10.45**
- LIGNEOUS CONJUNCTIVITIS, RIGHT EYE  
**H10.511**
- LIGNEOUS CONJUNCTIVITIS, LEFT EYE  
**H10.512**
- LIGNEOUS CONJUNCTIVITIS, BILATERAL  
**H10.513**
- LIGNEOUS CONJUNCTIVITIS, UNSPECIFIED EYE  
**H10.519**
- UNSPECIFIED SCLERITIS, RIGHT EYE  
**H15.001**
- UNSPECIFIED SCLERITIS, LEFT EYE  
**H15.002**
- UNSPECIFIED SCLERITIS, BILATERAL  
**H15.003**
- UNSPECIFIED SCLERITIS, UNSPECIFIED EYE  
**H15.009**
- ANTERIOR SCLERITIS, RIGHT EYE  
**H15.011**
- ANTERIOR SCLERITIS, LEFT EYE  
**H15.012**
- ANTERIOR SCLERITIS, BILATERAL  
**H15.013**
- ANTERIOR SCLERITIS, UNSPECIFIED EYE  
**H15.019**
- POSTERIOR SCLERITIS, RIGHT EYE  
**H15.031**
- POSTERIOR SCLERITIS, LEFT EYE  
**H15.032**
- POSTERIOR SCLERITIS, BILATERAL  
**H15.033**
- POSTERIOR SCLERITIS, UNSPECIFIED EYE  
**H15.039**
- SCLERITIS WITH CORNEAL INVOLVEMENT, RIGHT EYE  
**H15.041**
- SCLERITIS WITH CORNEAL INVOLVEMENT, LEFT EYE  
**H15.042**
- SCLERITIS WITH CORNEAL INVOLVEMENT, BILATERAL  
**H15.043**
- SCLERITIS WITH CORNEAL INVOLVEMENT, UNSPECIFIED EYE  
**H15.049**
- OTHER SCLERITIS, RIGHT EYE  
**H15.091**
- OTHER SCLERITIS, LEFT EYE  
**H15.092**
- OTHER SCLERITIS, UNSPECIFIED EYE  
**H15.099**
- UNSPECIFIED CORNEAL ULCER, RIGHT EYE  
**H16.001**
- UNSPECIFIED CORNEAL ULCER, LEFT EYE  
**H16.002**
- UNSPECIFIED CORNEAL ULCER, BILATERAL  
**H16.003**
- UNSPECIFIED CORNEAL ULCER, UNSPECIFIED EYE  
**H16.009**
- CENTRAL CORNEAL ULCER, RIGHT EYE  
**H16.011**
- CENTRAL CORNEAL ULCER, LEFT EYE  
**H16.012**
- CENTRAL CORNEAL ULCER, BILATERAL  
**H16.013**
- CENTRAL CORNEAL ULCER, UNSPECIFIED EYE  
**H16.019**
- RING CORNEAL ULCER, LEFT EYE  
**H16.022**
- RING CORNEAL ULCER, BILATERAL  
**H16.023**
- CORNEAL ULCER WITH HYPOPYON, RIGHT EYE  
**H16.031**
- CORNEAL ULCER WITH HYPOPYON, LEFT EYE  
**H16.032**
- CORNEAL ULCER WITH HYPOPYON, BILATERAL  
**H16.033**
- MARGINAL CORNEAL ULCER, RIGHT EYE  
**H16.041**
- MARGINAL CORNEAL ULCER, LEFT EYE  
**H16.042**
- MARGINAL CORNEAL ULCER, BILATERAL  
**H16.043**
- MOOREN'S CORNEAL ULCER, RIGHT EYE  
**H16.051**
- MOOREN'S CORNEAL ULCER, LEFT EYE  
**H16.052**
- MOOREN'S CORNEAL ULCER, BILATERAL  
**H16.053**
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