



Acthar[®] 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[®] GEL NDC# 63004-8710-1 5 mL multidose vial containing 80 USP units per mL

<p>4A. PLEASE SELECT AN FDA-APPROVED RECOMMENDED DOSE OR OTHER DOSE</p> <p><input type="checkbox"/> 40 UNITS, 2 TIMES A WEEK <input type="checkbox"/> 80 UNITS, 2 TIMES A WEEK</p> <p><input type="checkbox"/> OTHER DOSE: _____ <input type="checkbox"/> UNITS <input type="checkbox"/> mL</p> <p>SCHEDULE/FREQUENCY: _____</p> <p>ROUTE OF ADMINISTRATION: <input type="checkbox"/> INTRAMUSCULAR <input type="checkbox"/> SUBCUTANEOUS</p> <p>QUANTITY OF 5 mL MULTIDOSE VIALS: _____ REFILLS: _____</p>	<p>4D. ICD-10 CODE: _____</p> <p>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)</p>
<p>4B. TAPER INSTRUCTIONS <input type="checkbox"/> See attached taper schedule for Additional Taper Instructions</p> <p>ADDITIONAL SPECIAL INSTRUCTIONS, TITRATION OR TAPER DOSE, IF APPLICABLE:</p>	<p>4E. IDENTIFYING SUPPLIES IS MANDATORY FOR A COMPLETE PRESCRIPTION</p> <p>SYRINGE SIZE: QUANTITY:</p> <p><input type="checkbox"/> 1 mL <input type="checkbox"/> 3 mL <input type="checkbox"/> Other: _____ TOTAL: _____</p> <p>NEEDLE SIZE FOR DRAWING: QUANTITY:</p> <p><input type="checkbox"/> 20 G needle, 1" <input type="checkbox"/> Other: _____ TOTAL: _____</p> <p>NEEDLE SIZE FOR INJECTION: QUANTITY:</p> <p><input type="checkbox"/> 23 G needle, 5/8" <input type="checkbox"/> 23 G needle, 3/4"</p> <p><input type="checkbox"/> 23 G needle, 1" <input type="checkbox"/> Other: _____ TOTAL: _____</p> <p>SUPPLY REFILLS: _____ SHARPS CONTAINER: _____</p>
<p>4C. ALLERGIES</p> <p>PLEASE PROVIDE ALLERGY INFORMATION, IF APPLICABLE (Additional space provided on page 2):</p>	

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[®] 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.

PRESCRIBER SIGNATURE: Please sign only ONE LINE below

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

- For intravenous administration
- In infants under 2 years of age who have suspected congenital infections
- With concomitant administration of live or live attenuated vaccines in patients receiving immunosuppressive doses of Acthar
- 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 axis 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. Monitor blood pressure and sodium and potassium levels
- 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 gastrointestinal (GI) bleeding and gastric ulcer. There is also an increased risk for perforation in patients with certain GI disorders. Monitor for signs of perforation and 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 and Acthar activity
- There may be 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 in 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

- Commonly reported postmarketing adverse reactions for Acthar include injection site reaction, asthenic conditions (including fatigue, malaise, asthenia, and lethargy), fluid retention (including peripheral swelling), insomnia, headache, and blood glucose increased
- The most common adverse reactions for the treatment of infantile spasms (IS) are increased risk of infections, convulsions, hypertension, irritability, and pyrexia. Some patients with IS progress to other forms of seizures; IS sometimes masks these seizures, which may 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.actharhcp.com/Static/pdf/Acthar-PI.pdf>.

INDICATION AND USAGE

Acthar[®] Gel 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
- PERFORATED CORNEAL ULCER, RIGHT EYE
H16.071
- PERFORATED CORNEAL ULCER, LEFT EYE
H16.072
- PERFORATED CORNEAL ULCER, BILATERAL
H16.073
- UNSPECIFIED SUPERFICIAL KERATITIS, RIGHT EYE
H16.101
- UNSPECIFIED SUPERFICIAL KERATITIS, LEFT EYE
H16.102
- UNSPECIFIED SUPERFICIAL KERATITIS, BILATERAL
H16.103
- UNSPECIFIED SUPERFICIAL KERATITIS, UNSPECIFIED EYE
H16.109
- MACULAR KERATITIS, RIGHT EYE
H16.111
- MACULAR KERATITIS, LEFT EYE
H16.112
- MACULAR KERATITIS, BILATERAL
H16.113
- MACULAR KERATITIS, UNSPECIFIED EYE
H16.119
- FILAMENTARY KERATITIS, RIGHT EYE
H16.121
- FILAMENTARY KERATITIS, LEFT EYE
H16.122
- FILAMENTARY KERATITIS, BILATERAL
H16.123
- PUNCTATE KERATITIS, RIGHT EYE
H16.141
- PUNCTATE KERATITIS, LEFT EYE
H16.142
- PUNCTATE KERATITIS, BILATERAL
H16.143
- UNSPECIFIED KERATOCONJUNCTIVITIS, RIGHT EYE
H16.201
- UNSPECIFIED KERATOCONJUNCTIVITIS, LEFT EYE
H16.202
- UNSPECIFIED KERATOCONJUNCTIVITIS, BILATERAL
H16.203
- UNSPECIFIED KERATOCONJUNCTIVITIS, UNSPECIFIED EYE
H16.209
- KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJÖGREN'S, RIGHT EYE
H16.221
- KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJÖGREN'S, LEFT EYE
H16.222
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