

Enrollment Form

Please complete this application and submit **pages 1-2** by fax to 1-888-335-3264 or retain completed and patient-signed forms on file at your office if submission is entered via the EYLEA4U[®] ePortal.

BOLDED fields are required.
If information is missing, it may cause a delay in processing.

Section 1: Patient Information – Please input information as it appears on the patient's insurance card

First Name: _____ **Middle Initial:** _____ **Last Name:** _____ **Gender:** ☐ Male ☐ Female ☐ Other
Email: _____ **Date of Birth:** _____ **Home Phone:** _____ **Cell Phone:** _____
Address: _____ **City:** _____ **State:** _____ **ZIP:** _____
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ ☐ Patient Contact Information Attached
Alternate Contact/Caregiver Name: _____ **Alternate Contact/Caregiver Phone:** _____

Section 2: Patient Insurance Information

If the patient does not have insurance, the patient may qualify for the Patient Assistance Program (PAP). Please see PAP enrollment in sections 3 and 6.

Primary Payer Name: _____	Secondary Payer Name: _____
Primary Payer Plan: _____	Secondary Payer Plan: _____
Primary Payer Phone: _____	Secondary Payer Phone: _____
Policyholder Name: _____	Policyholder Name: _____
Primary Policy #: _____	Secondary Policy #: _____
Employer/Group #: _____	Employer/Group #: _____
Medicare Beneficiary ID# (Medicare/Medicare Advantage plans only): _____ If copy of insurance card(s) attached, check here ☐	

Section 3: Financial Information – Patient Assistance Program (PAP) Requests ONLY

How many people live in your household? _____

Total Annual Household Income (including salary/wages; Social Security income; disability income; any other income)*:

☐ \$0 to \$100,000 ☐ \$100,001 to \$150,000 ☐ Greater than \$150,000

*Supporting documentation may be required.
EYLEA4U may also ask for proof of income at any time for audit/verification.

Section 4: Patient Authorization

HIPAA Authorization

I have read and agree to the Authorization to Disclose/Use Health Information in Section 9.



Patient Signature: _____
Date: _____

Enrollment Into EYLEA4U Program Services

I have read and agree to enroll in EYLEA4U program services and to the Patient Certification included in Section 10 including, if applicable, that Regeneron may access my individual credit history from key reporting agencies.



Patient Signature: _____
Date: _____

Consent to Collect Information for Marketing Purposes (Optional)

Read the *Consent to Collect Information for Marketing Purposes* on page 6 and select the box to the right if you consent.

☐ I consent

Consent to Disclose Information for Marketing Purposes (Optional)

Read the *Consent to Disclose Information for Marketing Purposes* on page 6 and select the box to the right if you consent.

☐ I consent

Ok to Text? ☐ Yes ☐ No (By checking "Yes," I acknowledge that I have read the Text Messaging Consent in Section 10 and expressly consent to receive text messages by or on behalf of the Program.)

For more information on Regeneron's privacy practices, please read Regeneron's privacy policy, which is available at regeneron.com/privacy-notice.

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ / _____ / _____

Section 5: Product Selection/Diagnosis

Please select based on HCP clinical decision.


EYLEA HD[®]
(aflibercept) Injection 8 mg

☐ EYLEA HD[®] (aflibercept) Injection 8 mg

Primary diagnosis code (required) _____

Secondary diagnosis code _____

Other diagnosis code (may be used for PAP) _____

Has patient started treatment? ☐ Yes ☐ No

Anticipated date of treatment: _____


EYLEA[®]
(aflibercept) Injection 2 mg

☐ EYLEA[®] (aflibercept) Injection 2 mg

☐ Check here if diagnosis is same as EYLEA HD

Primary diagnosis code (required) _____

Secondary diagnosis code _____

Other diagnosis code (may be used for PAP) _____

Has patient started treatment? ☐ Yes ☐ No

Anticipated date of treatment: _____

Section 6: EYLEA4U[®] Program Support Requested

- ☐ Update patient record (Details updated?) _____
- ☐ Benefit verification
- ☐ Commercial Copay Card Program (commercial patients only)
- ☐ Patient Assistance Program (PAP)*
- *Contact EYLEA4U for eligibility.

Commercial Copay Program eligibility requires a diagnosis for an FDA-approved indication at time of injection. Refer to pages 7-9 for a listing of eligible diagnosis codes.

Claims, appeal, and PA support are available through the EYLEA4U Program. These support services are available for all patients enrolled in EYLEA4U. Please reach out directly to EYLEA4U to initiate services.

Section 7: Prescribing Physician Information

Site of Service: ☐ Physician Office ☐ Hospital Outpatient ☐ Ambulatory Surgical Center

Location Name: _____ Suite: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Billing Fax #: _____

Billing Entity NPI: _____ Billing Entity Tax ID#: _____

EYLEA4U Office Contact: _____ Phone: _____ Fax: _____ Email: _____

Physician Name: _____

Email: _____

Physician's NPI: _____

Physician's Tax ID#: _____

Physician's PTAN: _____

Section 8: Physician Authorization

Must be signed by the physician for all Enrollment Form submissions, including ePortal.

My signature certifies that the person named on this form is my patient; the information on this form, to the best of my knowledge is complete and accurate; that in my professional judgment, therapy with EYLEA HD and/or EYLEA is medically necessary for the patient identified on this form. I understand that my patient's information provided to Regeneron Pharmaceuticals, Inc., and its affiliates and agents (together, "Regeneron") is for the use of the EYLEA4U program, and I authorize EYLEA4U to verify my patient's insurance coverage; to assess, if applicable, my patient's eligibility for patient assistance and other support programs; and to otherwise administer EYLEA4U for the patient including facilitating enrollment into the EYLEA4U Program. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, to provide the individually identifiable health information on this form to reimbursement support programs such as EYLEA4U for these purposes. I further certify that I will retain in my files the complete patient-executed Enrollment Form, and that upon request, I will promptly provide a copy of this patient-executed Enrollment Form on file to EYLEA4U.

I certify that EYLEA HD and/or EYLEA received free of charge from the EYLEA4U Patient Assistance Program in response to this application, if any, will be used exclusively for the patient named on this form. I also certify that no claim for reimbursement for free product or related medical procedures and services will be submitted to any payer, including Medicare and Medicaid; and no free product may be sold, traded, bartered or distributed for sale and will otherwise comply with the EYLEA4U Patient Assistance Program terms and conditions. I understand that any free product distributed through the EYLEA4U Patient Assistance Program is not contingent on any purchase obligations. I consent to EYLEA4U contacting me by fax, mail, or email to provide additional information about EYLEA HD and/or EYLEA or EYLEA4U. I understand that Regeneron may revise, change, or terminate any program services at any time without notice to me.

In connection with my participation in the EYLEA4U Commercial Copay Card Program, I hereby represent and warrant that: a) I have verified that the patient does not have coverage for EYLEA HD and/or EYLEA under any state or federally funded health care program and has coverage for EYLEA HD and/or EYLEA under a commercial or private insurance plan and is receiving EYLEA HD and/or EYLEA for an FDA-approved indication; b) participation in the EYLEA4U Commercial Copay Card Program is not inconsistent with laws and regulations applicable to my medical practice or with any contract or arrangement with any third-party payer to which I will submit a bill or claim for reimbursement of EYLEA HD and/or EYLEA administered to the patient; c) I will comply with applicable obligations, if any, to disclose the acceptance of such payment to the applicable payers; and d) the bill or claim I submit to the insurer or patient for payment is separate from any bill or claim outside of product and administration or any other items or services provided to the patient.

 **Physician Signature:** _____ **Date:** _____

Signature required; this form cannot be processed without an original or stamped signature.

Section 9: Authorization to Disclose/Use Health Information

I authorize my health care providers and staff, my health insurer, health plan or programs that provide me health care benefits (together, "Health Insurers") and any specialty pharmacy(s) that dispense my medication to disclose to Regeneron Pharmaceuticals, Inc. and its affiliates, representatives, agents and contractors (together, "Regeneron") health information about me, including information related to my medical condition, treatment with EYLEA HD® (aflibercept) Injection and/or EYLEA® (aflibercept) Injection, health insurance coverage, claims, prescription, and referral to and enrollment in the EYLEA4U® Programs (together, "My Information"). My health care providers, Health Insurers, specialty pharmacy(s) and Regeneron may use and disclose My Information for the purposes of providing certain support services, including:

- to determine if I am eligible to participate in Regeneron's reimbursement and coverage assistance program(s), patient assistance programs and other support programs (together, "EYLEA4U Programs");
- for the operation and administration of the EYLEA4U Programs, including to communicate with me about the EYLEA4U Programs and my participation in the EYLEA4U Programs, and to evaluate and improve the EYLEA4U Programs and associated services provided;
- to investigate my health insurance coverage benefits;
- to obtain prior authorization for coverage/reimbursement;
- to assist with appeals of denied claims for coverage/reimbursement.

I understand and agree that my health care providers, Health Insurers and specialty pharmacy(s) may receive remuneration from Regeneron in exchange for disclosing My Information to Regeneron and/or for providing me with support services in connection with EYLEA HD and/or EYLEA or the EYLEA4U Programs. Once My Information has been disclosed to Regeneron, I understand that federal privacy laws may no longer protect it from further disclosure. However, Regeneron agrees to protect My Information by using and disclosing it only for the purposes authorized in this Authorization or as otherwise required by law.

I understand that if I refuse to sign this Authorization, I will not be able to participate in the EYLEA4U Programs, but it will not affect my eligibility to obtain medical treatment, my ability to seek payment for this treatment or affect my insurance enrollment or eligibility for insurance coverage.

Further, I understand that I may withdraw (take back) this Authorization at any time by mailing or faxing a written request to Regeneron at 6931 Arlington Rd, Suite 400, Bethesda, MD 20814; Fax: 1-888-335-3264. Withdrawal of this Authorization will end further uses and disclosures of My Information by the parties identified in this Authorization except to the extent those uses and disclosures have been made in reliance upon this Authorization.

This Authorization expires 18 months from the date support is last provided under any EYLEA4U Program, subject to applicable law, unless I withdraw it earlier. I understand that I may request a copy of this Authorization.

Section 10: Patient Certification/Patient Consent to Enroll in EYLEA4U Program Services

Please read the following carefully, then date and sign where indicated in Section 4 on page 1.

I am enrolling in the EYLEA4U® Program and authorize Regeneron Pharmaceuticals, Inc., and its affiliates, representatives, agents, and contractors (together, “Regeneron”) to provide me with assistance, as described in the Program Enrollment Form, such as coverage and reimbursement support, financial assistance, education, and other support programs (the “Program”). I agree that Regeneron may verify my eligibility for the Program, and I understand that such verification may include contacting me or my health care providers for additional information and/or reviewing additional financial, insurance, and/or medical information. I verify that the information on this form and other supporting documentation is complete and accurate to the best of my knowledge.

I agree to my enrollment in the EYLEA4U Commercial Copay Card Program if confirmed as eligible and understand that any assistance with my applicable cost-sharing or copayment for EYLEA HD® (aflibercept) Injection and/or EYLEA® (aflibercept) Injection will be made in accordance with the Program terms and conditions. I understand that patients who are enrolled in any federal health care program, including, without limitation, Medicare, Medicaid, TriCare, and Veterans Administration are not eligible to participate in the EYLEA4U Commercial Copay Card Program. I understand that the EYLEA4U Commercial Copay Card Program is not health insurance.

Patients **are not eligible** for the EYLEA4U Patient Assistance Program/need-based free drug if their employer, insurance plan, payor, or third-party administrator participates in an alternate funding program and requires them to (i) apply to the EYLEA4U Patient Assistance Program as a condition of, requirement for, or prerequisite to coverage of relevant Regeneron products, and/or (ii) denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or approval or denial of, eligibility for a manufacturer patient support program like the EYLEA4U Patient Assistance Program. I (or my legally authorized representative or guardian) am applying for assistance from the EYLEA4U Patient Assistance Program voluntarily. I have not been directed by my insurance plan, employer, payor or any other third-party administrator to seek assistance from the EYLEA4U Patient Assistance Program and I agree to inform the EYLEA4U Patient Assistance Program team if I am requested to apply to the EYLEA4U Patient Assistance Program by my insurance plan, employer, payor or any other third-party administrator. Further, I acknowledge that the EYLEA4U Patient Assistance Program team may take additional steps to verify my eligibility for the patient assistance program/need-based free drug. Therefore, if I am applying to the EYLEA4U Patient Assistance Program for either myself or on behalf of a patient, I authorize the EYLEA4U Patient Assistance Program to contact my/the patient’s employer, insurer and other third parties (such as pharmacy benefit managers and their affiliated partners) to verify prescription benefit design and coverage. If I subsequently learn that my insurance plan, employer, payor and/or other third-party administrator uses an alternate funding program, I agree to inform the EYLEA4U Patient Assistance Program team immediately and understand that I will no longer be eligible for support.

Section 10: Patient Certification/Patient Consent to Enroll in EYLEA4U Program Services (cont'd)

To qualify for the EYLEA4U Patient Assistance Program, I understand that I must meet certain income and other eligibility requirements. EYLEA4U may ask for proof of income at any time for the purpose of audit/verification. If requested, I agree to provide proof of income within thirty (30) days of the request. Continuation in the program is conditioned upon timely verification of income. In addition, I agree to notify EYLEA4U promptly if my insurance situation changes. I also agree that Regeneron Pharmaceuticals, Inc. and its affiliates, representatives, agents, and contractors (together, "Regeneron") may verify my eligibility for the EYLEA4U Program, and I understand that such verification may include contacting me or my health care provider for additional information and/or reviewing additional financial, insurance, and/or medical information. I authorize Regeneron to use my Social Security number and/or additional demographic information to access reports on my individual credit history from consumer reporting agencies for purposes of determining my income eligibility for the Patient Assistance Program. I understand that, upon request, Regeneron will tell me whether an individual consumer report was requested and the name and address of the agency that furnished it. I further understand and authorize Regeneron to use any consumer reports about me and information collected from me, along with other information they obtain from public and other sources, including the use of third parties to conduct services that may improve the cross-border processing of my personal data outside of the US, to estimate my income in conjunction with the Patient Assistance Program eligibility determination process.

If I am applying for the Patient Assistance Program (PAP), I confirm my agreement with the conditions set forth. If I am approved for the PAP or if I otherwise receive no cost product under the Program, I certify that neither I nor anyone acting on my behalf will seek reimbursement from any third-party insurer or payer for product I receive at no cost while I am enrolled in the Program. If I am enrolled in a Medicare Prescription Drug Plan, I acknowledge that the value of any free product I receive cannot be counted toward my True Out-of-Pocket (TrOOP) expenses and that Regeneron will notify my plan of the assistance received through the PAP.

I understand that I do not have to enroll in the Program, and that I can still receive EYLEA HD and/or EYLEA, as prescribed by my health care providers and staff. Participation in the Program does not obligate me to use any specific health care provider, and I am free to change providers at any time. I may opt out of individual support offered by the Program, including the EYLEA4U Commercial Copay Card Program, or opt out of the Program entirely, at any time by notifying a Program representative by: calling 1-855-EYLEA4U (1-855-395-3248, Option 4); sending a letter to EYLEA4U, 6931 Arlington Rd, Suite 400, Bethesda, MD 20814; faxing 1-888-335-3264; or emailing unsubscribe@regeneron.com. I also understand that I must inform the Program if my financial circumstance, insurance, or any other eligibility criteria changes. I also understand that the Program may be revised, changed, or terminated in whole or in part, at any time and without notice.

Section 10: Patient Certification/Patient Consent to Enroll in EYLEA4U Program Services (cont'd)

Consent to Collect Information for Marketing Purposes

I authorize Regeneron to collect my Health Information to contact me with marketing communications about other Regeneron products and services. I understand I am not required to consent to collection of my Health Information for these marketing purposes, and I can still enroll in the Program even if I do not consent to receive marketing communications about other Regeneron products and services. If I consent, I understand that I may withdraw my consent at any time.

Consent to Disclose Information for Marketing Purposes

I authorize Regeneron to disclose my Health Information to contact me with marketing communications about other Regeneron products and services. I understand that I am not required to consent to the disclosure of my Health Information for these marketing purposes, and I can still enroll in the Program even if I do not consent to disclose my Health Information to receive marketing communications about other Regeneron products and services. If I consent, I understand that I may withdraw my consent at any time.

Withdraw Consent

You may withdraw your consent to any of the above by notifying a Program representative by: calling 1-855-EYLEA4U (1-855-395-3248, Option 4); sending a letter to EYLEA4U, 6931 Arlington Rd, Suite 400, Bethesda, MD 20814; faxing 1-888-335-3264; or emailing unsubscribe@regeneron.com.

Text Messaging & Calling Consent

I acknowledge that by checking the Text/Call Consent box on page 1, I further authorize Regeneron to contact me by phone or SMS/text message at the telephone number I have provided, to provide me with resources and services related to EYLEA HD and/or EYLEA or the Program, and to send marketing communications to me. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out of future text messages at any time by texting STOP to 39842 from my mobile phone, and that I can get help for text messages by texting HELP to 39842. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. Message and data rates may apply. I UNDERSTAND THAT THESE COMMUNICATIONS MAY USE PRERECORDED/ARTIFICIAL VOICE MESSAGES AND/OR AN AUTOMATED SYSTEM. I ALSO UNDERSTAND THAT MY CONSENT IS NOT REQUIRED AS A CONDITION OF PURCHASING ANY GOODS OR SERVICES FROM REGENERON OR ITS AFFILIATES.

Wet Age-Related Macular Degeneration (Wet AMD)

Exudative age-related macular degeneration	Right eye	Left eye	Bilateral	Unspecified eye
With active choroidal neovascularization	H35.3211	H35.3221	H35.3231	H35.3291
With inactive choroidal neovascularization	H35.3212	H35.3222	H35.3232	H35.3292
With inactive scar	H35.3213	H35.3223	H35.3233	H35.3293
Stage unspecified	H35.3210	H35.3220	H35.3230	H35.3290

Macular Edema Following Retinal Vein Occlusion (MEfRVO)

Central retinal vein occlusion	Right eye	Left eye	Bilateral	Unspecified eye
With macular edema	H34.8110	H34.8120	H34.8130	H34.8190
Tributary (branch) retinal vein occlusion	Right eye	Left eye	Bilateral	Unspecified eye
With macular edema	H34.8310	H34.8320	H34.8330	H34.8390

Diabetic Macular Edema (DME)

Diabetes mellitus due to underlying condition with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	E08.3211	E08.3212	E08.3213	E08.3219
Mild nonproliferative diabetic retinopathy without macular edema	E08.3291	E08.3292	E08.3293	
Moderate nonproliferative diabetic retinopathy with macular edema	E08.3311	E08.3312	E08.3313	E08.3319
Moderate nonproliferative diabetic retinopathy without macular edema	E08.3391	E08.3392	E08.3393	
Severe nonproliferative diabetic retinopathy with macular edema	E08.3411	E08.3412	E08.3413	E08.3419
Severe nonproliferative diabetic retinopathy without macular edema	E08.3491	E08.3492	E08.3493	
Proliferative diabetic retinopathy with macular edema	E08.3511	E08.3512	E08.3513	E08.3519
Unspecified diabetic retinopathy with macular edema	E08.311			
Unspecified diabetic retinopathy without macular edema	E08.319			

Drug or chemical induced diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	E09.3211	E09.3212	E09.3213	E09.3219
Mild nonproliferative diabetic retinopathy without macular edema	E09.3291	E09.3292	E09.3293	
Moderate nonproliferative diabetic retinopathy with macular edema	E09.3311	E09.3312	E09.3313	E09.3319
Moderate nonproliferative diabetic retinopathy without macular edema	E09.3391	E09.3392	E09.3393	
Severe nonproliferative diabetic retinopathy with macular edema	E09.3411	E09.3412	E09.3413	E09.3419
Severe nonproliferative diabetic retinopathy without macular edema	E09.3491	E09.3492	E09.3493	
Proliferative diabetic retinopathy with macular edema	E09.3511	E09.3512	E09.3513	E09.3519
Unspecified diabetic retinopathy with macular edema	E09.311			
Unspecified diabetic retinopathy without macular edema	E09.319			

Type 1 diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	E10.3211	E10.3212	E10.3213	E10.3219
Mild nonproliferative diabetic retinopathy without macular edema	E10.3291	E10.3292	E10.3293	
Moderate nonproliferative diabetic retinopathy with macular edema	E10.3311	E10.3312	E10.3313	E10.3319
Moderate nonproliferative diabetic retinopathy without macular edema	E10.3391	E10.3392	E10.3393	
Severe nonproliferative diabetic retinopathy with macular edema	E10.3411	E10.3412	E10.3413	E10.3419
Severe nonproliferative diabetic retinopathy without macular edema	E10.3491	E10.3492	E10.3493	
Proliferative diabetic retinopathy with macular edema	E10.3511	E10.3512	E10.3513	E10.3519
Unspecified diabetic retinopathy with macular edema	E10.311			
Unspecified diabetic retinopathy without macular edema	E10.319			

Please see full Prescribing Information for EYLEA HD and EYLEA, available at EYLEAHDhcp.com

Diabetic Macular Edema (DME) (cont'd)
Type 2 diabetes mellitus with...

	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	E11.3211	E11.3212	E11.3213	E11.3219
Mild nonproliferative diabetic retinopathy without macular edema	E11.3291	E11.3292	E11.3293	
Moderate nonproliferative diabetic retinopathy with macular edema	E11.3311	E11.3312	E11.3313	E11.3319
Moderate nonproliferative diabetic retinopathy without macular edema	E11.3391	E11.3392	E11.3393	
Severe nonproliferative diabetic retinopathy with macular edema	E11.3411	E11.3412	E11.3413	E11.3419
Severe nonproliferative diabetic retinopathy without macular edema	E11.3491	E11.3492	E11.3493	
Proliferative diabetic retinopathy with macular edema	E11.3511	E11.3512	E11.3513	E11.3519
Unspecified diabetic retinopathy with macular edema	E11.311			
Unspecified diabetic retinopathy without macular edema	E11.319			

Other specified diabetes mellitus with...

	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy with macular edema	E13.3211	E13.3212	E13.3213	E13.3219
Mild nonproliferative diabetic retinopathy without macular edema	E13.3291	E13.3292	E13.3293	
Moderate nonproliferative diabetic retinopathy with macular edema	E13.3311	E13.3312	E13.3313	E13.3319
Moderate nonproliferative diabetic retinopathy without macular edema	E13.3391	E13.3392	E13.3393	
Severe nonproliferative diabetic retinopathy with macular edema	E13.3411	E13.3412	E13.3413	E13.3419
Severe nonproliferative diabetic retinopathy without macular edema	E13.3491	E13.3492	E13.3493	
Proliferative diabetic retinopathy with macular edema	E13.3511	E13.3512	E13.3513	E13.3519
Unspecified diabetic retinopathy with macular edema	E13.311			
Unspecified diabetic retinopathy without macular edema	E13.319			

Diabetic Retinopathy (DR)
Diabetes mellitus due to underlying condition with...

	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	E08.3291	E08.3292	E08.3293	E08.3299
Moderate nonproliferative diabetic retinopathy without macular edema	E08.3391	E08.3392	E08.3393	E08.3399
Severe nonproliferative diabetic retinopathy without macular edema	E08.3491	E08.3492	E08.3493	E08.3499
Proliferative diabetic retinopathy with traction retinal detachment involving the macula	E08.3521	E08.3522	E08.3523	E08.3529
Proliferative diabetic retinopathy with traction retinal detachment not involving the macula	E08.3531	E08.3532	E08.3533	E08.3539
Proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment	E08.3541	E08.3542	E08.3543	E08.3549
Stable proliferative diabetic retinopathy	E08.3551	E08.3552	E08.3553	E08.3559
Proliferative diabetic retinopathy without macular edema	E08.3591	E08.3592	E08.3593	E08.3599
Unspecified diabetic retinopathy without macular edema	E08.319			

Drug or chemical induced diabetes mellitus with...

	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	E09.3291	E09.3292	E09.3293	E09.3299
Moderate nonproliferative diabetic retinopathy without macular edema	E09.3391	E09.3392	E09.3393	E09.3399
Severe nonproliferative diabetic retinopathy without macular edema	E09.3491	E09.3492	E09.3493	E09.3499
Proliferative diabetic retinopathy with traction retinal detachment involving the macula	E09.3521	E09.3522	E09.3523	E09.3529
Proliferative diabetic retinopathy with traction retinal detachment not involving the macula	E09.3531	E09.3532	E09.3533	E09.3539

Diabetic Retinopathy (DR) (cont'd)

Drug or chemical induced diabetes mellitus with... (cont'd)	Right eye	Left eye	Bilateral	Unspecified eye
Proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment	E09.3541	E09.3542	E09.3543	E09.3549
Stable proliferative diabetic retinopathy	E09.3551	E09.3552	E09.3553	E09.3559
Proliferative diabetic retinopathy without macular edema	E09.3591	E09.3592	E09.3593	E09.3599
Unspecified diabetic retinopathy without macular edema	E09.319			
Type 1 diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	E10.3291	E10.3292	E10.3293	E10.3299
Moderate nonproliferative diabetic retinopathy without macular edema	E10.3391	E10.3392	E10.3393	E10.3399
Severe nonproliferative diabetic retinopathy without macular edema	E10.3491	E10.3492	E10.3493	E10.3499
Proliferative diabetic retinopathy with traction retinal detachment involving the macula	E10.3521	E10.3522	E10.3523	E10.3529
Proliferative diabetic retinopathy with traction retinal detachment not involving the macula	E10.3531	E10.3532	E10.3533	E10.3539
Proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment	E10.3541	E10.3542	E10.3543	E10.3549
Stable proliferative diabetic retinopathy	E10.3551	E10.3552	E10.3553	E10.3559
Proliferative diabetic retinopathy without macular edema	E10.3591	E10.3592	E10.3593	E10.3599
Unspecified diabetic retinopathy without macular edema	E10.319			
Type 2 diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	E11.3291	E11.3292	E11.3293	E11.3299
Moderate nonproliferative diabetic retinopathy without macular edema	E11.3391	E11.3392	E11.3393	E11.3399
Severe nonproliferative diabetic retinopathy without macular edema	E11.3491	E11.3492	E11.3493	E11.3499
Proliferative diabetic retinopathy with traction retinal detachment involving the macula	E11.3521	E11.3522	E11.3523	E11.3529
Proliferative diabetic retinopathy with traction retinal detachment not involving the macula	E11.3531	E11.3532	E11.3533	E11.3539
Proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment	E11.3541	E11.3542	E11.3543	E11.3549
Stable proliferative diabetic retinopathy	E11.3551	E11.3552	E11.3553	E11.3559
Proliferative diabetic retinopathy without macular edema	E11.3591	E11.3592	E11.3593	E11.3599
Unspecified diabetic retinopathy without macular edema	E11.319			
Other specified diabetes mellitus with...	Right eye	Left eye	Bilateral	Unspecified eye
Mild nonproliferative diabetic retinopathy without macular edema	E13.3291	E13.3292	E13.3293	E13.3299
Moderate nonproliferative diabetic retinopathy without macular edema	E13.3391	E13.3392	E13.3393	E13.3399
Severe nonproliferative diabetic retinopathy without macular edema	E13.3491	E13.3492	E13.3493	E13.3499
Proliferative diabetic retinopathy with traction retinal detachment involving the macula	E13.3521	E13.3522	E13.3523	E13.3529
Proliferative diabetic retinopathy with traction retinal detachment not involving the macula	E13.3531	E13.3532	E13.3533	E13.3539
Proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment	E13.3541	E13.3542	E13.3543	E13.3549
Stable proliferative diabetic retinopathy	E13.3551	E13.3552	E13.3553	E13.3559
Proliferative diabetic retinopathy without macular edema	E13.3591	E13.3592	E13.3593	E13.3599
Unspecified diabetic retinopathy without macular edema	E13.319			

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