



Prescribing Healthcare Professional Informed Consent

I, _____ hereby give any authorised representative of Bayer (Pty) Ltd, S Buys (Pty) Ltd t/a ScriptWise, consent to interact with my patient their medical scheme, administrator, managed care organisation or any other related party, to deal with any issue concerning the payment for EYLEA® that I have prescribed, including facilitating the reimbursement of that medication. All data collected is managed in a confidential manner. I confirm that I have obtained my patient's written consent to provide Bayer and/or Scriptwise with the aforementioned information for the purposes of reimbursement.

I am in agreement with his/her participation in the EYLEA Patient Assistance Program.

I hereby agree to be contacted by Bayer Pharmacovigilance Department with regards to follow up or additional information required for adverse events reported.

I am free to withdraw this consent at any time, provided I advise Bayer and Scriptwise of the withdrawal, in writing, using the following:

Email: ophthalmology@scriptwise.co.za or fax number: 086 534 8985

Name of institution, if any, where patient is being treated	
Practice Number	
MP Number	
Telephone numbers of healthcare provider	
Facsimile number of healthcare provider	
E-mail address of healthcare provider	
Physical address of healthcare provider	

Prescribing HCP Name and Surname

Date

Signature