INVELTYS™
(loteprednol etabonate ophthalmic suspension) 1%

To Whom It May Concern:

I am an enrollee in your prescription drug plan, and this letter is to advise you that I have been prescribed INVELTYS™ (loteprednol etabonate ophthalmic suspension) 1% by my physician. I am purchasing INVELTYS™ outside of my prescription drug benefit with the INVELTYS™ Co-pay Program sponsored by Kala Pharmaceuticals.

I have agreed not to seek reimbursement for my purchase of INVELTYS™ in accordance with the Terms and Conditions of the INVELTYS™ Co-pay Program. I have also agreed that I will not count the purchase of INVELTYS™ toward my true out-of-pocket expenses, and I will continue to use the INVELTYS™ Co-pay Program for as long as I take the medication during the current calendar year.

If you have questions about the INVELTYS™ Co-pay Program, please contact the program administrator at 866.255.9039 (press “5” for a live operator), Monday to Friday, from 8 am to 8 pm ET.

Sincerely,

NAME: _____

PRESCRIPTION PLAN: _____

PRESCRIPTION PLAN MEMBERSHIP ID NUMBER: _____

DATE: _____

DATE OF BIRTH: _____

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