ELMIRON® CASE & CLAIM DATA FORM

I. CLAIMANT INFO

Injured Person's Name: _____ Date of Death (if any): _____

Injured Person's DOB: _____ Estate Rep.'s Name: _____

Injured Person's SSN: _____ Estate Rep.'s DOB: _____

Injured Person's State of Residence: _____ Estate Rep.'s SSN: _____

Case Filed? Yes ☐ No ☐ Estate Rep.'s State of Residence: _____

Jurisdiction of Case Filing: _____ Case No. _____

II. USE INFO

A. Date of first ELMIRON® Use: _____

B. Date of last ELMIRON® Use: _____

D. Is Claimant still using ELMIRON®? Yes ☐ No ☐

III. MEDICAL DIAGNOSIS

A. Pigmentary Maculopathy Dx: Yes ☐ No ☐ Date of Dx: _____

B. Elmiron/PPS Maculopathy Dx: Yes ☐ No ☐ Date of Dx: _____

C. Did Claimant ever (prior to maculopathy dx) use any of the following medications for more than 6 mos.: Chloroquine/Hydroxychloroquine, Clofazimine, Phenothiazine, Deferoxamine. Yes ☐ No ☐

_____

D. OTHER / PRIOR DIAGNOSES:

☐ Hereditary Pigmentary Maculopathy: Yes ☐ No ☐

☐ Secondary Pigmentary Maculopathy: Yes ☐ No ☐

☐ Dry Age-related Macular Degeneration: Yes ☐ No ☐

☐ Wet Age-related Macular Degeneration: Yes ☐ No ☐

☐ Toxic Maculopathy: Yes ☐ No ☐

☐ Hereditary Dystrophy: Yes ☐ No ☐

☐ Pattern Dystrophy: Yes ☐ No ☐

☐ Unspecified Macular Degeneration: Yes ☐ No ☐

☐ Any other type of Maculopathy: Yes ☐ No ☐

☐ Retinal Damage: Yes ☐ No ☐

If Claimant was not diagnosed with one of the above conditions, please identify the condition alleged to have been caused by ELMIRON®: _____

IV. IMAGING

Has Claimant undergone any of the following Imaging Tests?

☐ Fundus Autofluoresence Imaging? Yes ☐ No ☐ Year of Test:_____; Dx:_____

☐ Near Infrared Reflectance? Yes ☐ No ☐ Year of Test:_____; Dx:_____

☐ Optical Coherence Tomography (OCT)? Yes ☐ No ☐ Year of Test:_____; Dx:_____

☐ Color Fundus Photography? Yes ☐ No ☐ Year of Test:_____; Dx:_____