Ozurdex® (dexamethasone intravitreal implant) 0.7 mg

OZURDEX® SAVINGS PROGRAM PHYSICIAN REIMBURSEMENT REQUEST FORM

*Required information.

Allergan EyeCue℠

Thank you for using the OZURDEX® Savings Program. In order to process reimbursement, please complete this form within 180 days from date of service and upload to AllerganEyeCue.com or fax it, along with the required supporting documentation listed at the bottom of this page, to 1-866-676-4069. If your patient qualifies, you should receive a check in the mail in 4 to 6 weeks.

PATIENT

Patient first name*: _____ Patient last name*: _____ Date of birth*: ___/___/____

Patient Member ID*: _____

This is the number you receive after enrollment.

PHYSICIAN

Reimbursement check will be mailed to the address on the Explanation of Benefits (EOB).

Physician first name*: _____ Physician last name*: _____

Office contact email address*: _____

SUPPORTING DOCUMENTS TO INCLUDE

- Completed OZURDEX® Savings Program Reimbursement Request Form
- HCFA 1500 form
- EOB document(s): Should be obtained from the patient's insurer

COPAY ATTESTATION

I, _____
Physician's name*

hereby attest that the patient listed above, on _____ paid a copay of at least $50 for each OZURDEX® injection. I also attest that all appropriate steps were completed to determine the appropriate copay for my patient and that the information submitted to *Allergan EyeCue*℠ is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of data may be subject to certain fines and/or liabilities. I understand that this information will be used for operational purposes as part of the OZURDEX® Savings Program from Allergan.
Date of service*

PHYSICIAN SIGNATURE (REQUIRED)

Physician signature* _____ **Date*** _____

Complete and upload all materials to AllerganEyeCue.com or fax to 1-866-676-4069.
Questions? Contact our Help Desk at 1-866-698-7339 or visit AllerganEyeCue.com.