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, estimated time for reimbursement is 3 days (ACH) or 2 to 4 weeks (check).

PATIENT

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

Patient member ID*: _____

This is the number you receive after enrollment.

PHYSICIAN

Reimbursement checks will be mailed to the address on the Explanation of Benefits (EOB); not applicable to ACH payment.

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

Office contact email address*: _____

For fax users only: Please indicate payment preference type for claims reimbursement†:

☐ Electronic payment via ACH ☐ Check

†Note: Registered portal users with an indicated payment preference in their account profile will receive reimbursement based on the selected method.

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 or delegate's name

hereby attest that I am the prescribing physician or a delegate authorized to sign on behalf of the prescribing physician and that the patient listed above, on _____, received an OZURDEX® injection as part of the OZURDEX® Savings Program from Allergan®. 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 OR DELEGATE SIGNATURE (REQUIRED)

Physician or delegate 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.

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