**Call: 1-866-OZURDEX (1-866-698-7339)** **Fax: 1-866-676-4069** **Hours of operation: M-F, 9 AM-8 PM ET**

**Visit: AllerganEyeCue.com**

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 receive reimbursement, you must submit this form within **180 days** from date of service by faxing it, along with the required supporting documentation listed below, to **1-866-676-4069**. Supporting documents can also be submitted at AllerganEyeCue.com. 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

Supporting documents to include:

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

## ATTESTATION

I, _____,
Physician's or delegate's name

hereby attest that I am the prescribing physician or a delegate authorized on behalf of the prescribing physician and that the patient listed above, on _____, received OZURDEX® as part of the OZURDEX® Savings Program
Date of service*

from Allergan, an AbbVie company. I also attest that all appropriate steps were completed to determine the appropriate patient out-of-pocket costs and that the information submitted to AbbVie 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.

**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.**

**IMPORTANT INFORMATION:** By submitting this form, you certify that you are not seeking reimbursement under any federal, state, or other government program for this prescription for OZURDEX®, a product of Allergan, an AbbVie company, and that you and the patient listed herein agree to comply with the OZURDEX Savings Program Terms, Conditions, and Eligibility Criteria available and printable at www.OZURDEXSavingsProgram.com/termsandconditions. AbbVie, its affiliates, collaborators, and agents ("AbbVie") will use the information collected about you and your patient to provide and manage *Allergan EyeCue* services and the OZURDEX Savings Program and to perform research and analytics on a de-identified basis. For more information about the categories of personal information collected by AbbVie and the purposes for which AbbVie uses personal information, visit www.abbvie.com/privacy. **Please share this information with your patient.**

Allergan an AbbVie company


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