Ozurdex® (dexamethasone intravitreal implant) 0.7 mg

Co-pay Attestation

I, _____
Physician's name

hereby attest that the patient, _____, on _____
Patient's name Date of Service

paid a co-pay of at least $50 for each OZURDEX® injection. I also attest that all appropriate steps were completed to determine the appropriate co-pay for my patient, and that the information submitted to Truveris, Inc., 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.

_____
Physician's signature

_____
Physician's practice name

_____
Date

This form should be uploaded as part of your submission for reimbursement, using either the online portal at OzurdexSavingsProgram.com or via fax at 1-347-630-0347.