Enroll in the OZURDEX® Savings Program

Ozurdex® (dexamethasone intravitreal implant) 0.7 mg

Patients pay as little as $50* for OZURDEX®

Simple steps to activate savings

1. CHECK YOUR ELIGIBILITY

To be eligible, you must:

- ✓ Be a resident of the United States (or its territories) and at least 18 years of age
- ✓ Be prescribed OZURDEX® according to its approved FDA labeling
- ✓ Receive treatment during or after December 2017
- ✓ Have commercial or private health insurance
- ✓ Have insurance coverage for OZURDEX® for an approved use
- ✓ Have no government-sponsored insurance coverage
- ✓ Have a household income that meets the following requirements:

Income limits by household size†

1	$60,000
2-4	$125,000
5+	$150,000

Patients are not eligible if they have government insurance (eg, prescriptions are paid in part or full by any state or federally funded programs, including but not limited to Medicare, Medicaid, Medigap, Veterans Affairs [VA], Department of Defense [DoD], CHAMPVA, or TRICARE)

2. FILL OUT THE ENROLLMENT FORM ON THE BACK OF THIS PAGE

3. INCLUDE INSURANCE VERIFICATION DOCUMENT

- A copy of your latest insurance card

4. FAX TO 1-347-630-0347

When should you enroll?

You should enroll before your physician treats you with OZURDEX®.

Use the fax enrollment form on reverse side—or enroll online at OzurdexSavingsProgram.com

*The maximum benefit per implant is $1000.

†Household = tax filer + spouse + number of tax dependents. Follow these basic rules when including members of your household: (1) include your spouse if you're legally married; (2) if you plan to claim someone as a tax dependent, do include them on your application; (3) if you won't claim someone as a tax dependent, don't include them.

Patient income verification requires a request for credit information, but this request will not impact the patient's credit score.

FAX

Attention: Truveris
Fax Number: 1-347-630-0347
Number of pages:

Ozurdex® (dexamethasone intravitreal implant) 0.7 mg

OZURDEX® Savings Program Patient Enrollment Form

Please provide the following information to verify your eligibility for the OZURDEX® Savings Program.

This program is administered on behalf of Allergan by Truveris.

Form must be complete. Please do not leave any blanks.

PATIENT INFORMATION

First name:_____ Last name:_____

Email address:_____ Telephone:_____

Date of birth:_____ Street address:_____

City:_____ State:_____ Zip code:_____

Physician's office name:_____ Physician's office phone:_____

Physician's office email:_____

☐ Check this box if you are a patient reenrolling in the OZURDEX® Savings Program, and provide your member ID:_____

VERIFICATION INFORMATION

Social Security number (SSN):_____ Your SSN is required to verify that your income qualifies for this program.Your most recent federal tax return may be requested as well, but it is not required right now.

Insurance group number:_____ Insurance member ID:_____

Policy holder (select one): ☐ Patient ☐ Patient's spouse ☐ Patient's parent ☐ Other

Diagnosis/What condition OZURDEX® will be used to treat _____

REMEMBER TO INCLUDE INSURANCE VERIFICATION DOCUMENT
(LISTED UNDER STEP 3 ON THE REVERSE SIDE OF THIS FORM)

All boxes below must be checked and this form must be signed and dated

By signing below, I hereby certify, agree to, and affirm the following statements:

☐ I certify that I am not enrolled in a federal- or state-funded prescription drug benefit program, such as Medicare, Medicaid, or any private indemnity or HMO insurance plan that reimburses the patient for the entire cost of his/her prescription drugs. I also certify that I am not Medicare-eligible and enrolled in an employer-sponsored health plan or prescription drug benefit program for retirees. I further certify that, should I begin receiving prescription benefits from one of these types of programs at any time, I will no longer participate in this savings program.

☐ I agree to this certification and accept the Program Terms, Conditions, and Eligibility Criteria available at OzurdexSavingsProgram.com.

☐ I certify that I am a resident of the United States, Puerto Rico, or Guam.

☐ I hereby agree and consent that the Allergan program administrator (Truveris, Inc.) may request consumer credit information on my behalf for the purpose of determining my eligibility for this program. (This request will not impact your credit score.)

☐ I certify that all of my responses are truthful and accurate to the best of my knowledge.

Patient Signature _____ Date_____

Fax all materials to: 1-347-630-0347

Questions? Contact our Help Desk at 1-855-454-6369