OZURDEX PATIENT ASSISTANCE® PROGRAM

Thank you for your interest in the OZURDEX PATIENT ASSISTANCE® Program for uninsured and underinsured patients who have insufficient resources to pay for their medication. To assist these patients, Allergan, Inc. is donating OZURDEX® (dexamethasone intravitreal implant) 0.7 mg applicators for qualifying patients at no charge. Cash payments are not involved.

Please complete the application for provider sponsorship and patient enrollment. In addition, please note that the provider and patient must complete the following important steps:

1. The provider sponsor must sign the Certification and Consent Statement on the completed application form.
2. The patient must sign the Certification and Consent Statement on the completed application form.
3. The patient must submit an acceptable form of the patients (or guardian's) income documentation.
4. The patient must complete and sign the attached HIPAA Authorization for the Use and Disclosure of Patient Information.

   Acceptable forms of income documentation include one of the following:
   - 1040, 1040A or 1099 from the most recent tax year
   - W-2
   - Social Security Statement

Please remember that patients are not eligible for consideration to participate in the OZURDEX PATIENT ASSISTANCE® Program until we receive the necessary form and income documentation.

Once the completed application is signed and the income documentation is collected, please mail or fax them to the OZURDEX PATIENT ASSISTANCE® Program. If you have any questions or need personal assistance, please call us at 1-866-OZURDEX between 9:00AM and 8:00PM EST.

Thank you for helping your financially needy patients to gain access to OZURDEX® by participating as a provider sponsor.

Sincerely,

The OZURDEX PATIENT ASSISTANCE® Program

OZURDEX PATIENT ASSISTANCE® Program
PO Box 1308 • San Bruno, CA 94066 • Phone: 1-866-OZURDEX • Fax: 1-866-676-4069

OZURDEX PATIENT ASSISTANCE® PROGRAM

Date: _____

PROVIDER SPONSOR INFORMATION

Provider Sponsor Name: | Contact Person and Title:

Address: | City: | State: | Zip:

Phone Number: | Fax Number:

Facility Name: | ☐ Physician's Office ☐ Hospital ☐ Other

License Number: | NPI:

Please provide contact person and address for product shipment (if different from above):

Provider Sponsor Name: | Contact Person and Title:

Address: | City: | State: | Zip:

Phone Number: | Fax Number:

Diagnosis (ICD-9 Code): | Estimated Dose (in applicators):

TREATMENT INFORMATION

I certify that I have read the Sponsor Certification and Consent Statement in full and that I understand and agree to the terms stated in the Declaration by signing below.

Provider Sponsor's Signature (required) | Date Signed (required)

PATIENT INFORMATION

Patient Full Name: | Social Security Number:

Address: | City: | State: | Zip:

Phone Number: | Date of Birth:

Number of members in household: | U.S. Resident (including Puerto Rico and U.S. Territories): ☐Yes ☐No

Patient's annual gross household income: $ | Income Source: ☐1040 ☐1040A ☐1099 ☐W-2 ☐Social Security Statement

I certify that I have read the Patient Certification and Consent Statement in full and that I understand and agree to the terms stated in the Declaration by signing below.

Patient's Signature (required) | Date Signed (required)

Please provide documentation verifying your income by attaching a copy of your 1040, 1040A, or 1099 from the most recent tax year, W-2, or Social Security Statement.

INSURANCE INFORMATION

☐HMO/EPO ☐PPO ☐POS ☐Indemnity ☐Medicare ☐Medicaid ☐No Insurance

Primary Insurance Company:

Policy Number: | Group Number:

Address:

City: | State: | Zip:

Phone Number:

Subscriber's Name | Date of Birth:

Subscriber's Relationship to Patient:

Secondary Insurance Company:

Policy Number: | Group Number:

Address:

City: | State: | Zip:

Phone Number:

Subscriber's Name | Date of Birth:

Subscriber's Relationship to Patient:

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OZURDEX PATIENT ASSISTANCE® PROGRAM

PLEASE READ DECLARATION BEFORE SIGNING FRONT OF FORM

PROVIDER SPONSOR CERTIFICATION AND CONSENT STATEMENT

The OZURDEX PATIENT ASSISTANCE® Program offers assistance to financially eligible patients who need OZURDEX® (dexamethasone intravitreal implant) 0.7 mg treatment. Patients who are uninsured or underinsured and are unable to afford the cost of therapy may be eligible for enrollment. While Allergan makes every effort to grant aid when needed and appropriate, the program is limited in available resources and may be discontinued at any time, without further notice.

I certify that the use of OZURDEX® is medically necessary and appropriate and that I will be supervising the patient's treatment accordingly.
I further certify that, to the best of my knowledge, this patient has no medical insurance coverage for OZURDEX®, including Medicaid/Medicare or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I agree not to bill or collect from the patient or any government or private payer, or to trade, sell, barter for or return for credit any OZURDEX® provided under the OZURDEX PATIENT ASSISTANCE® Program.

I also certify that my patient understands that these costs are his/her responsibility if I am unable to waive the administration fee.

I agree that any OZURDEX® I receive for the patient named in the application will be used only for this patient.

I also understand that Allergan, Inc. reserves the right to modify or discontinue the OZURDEX PATIENT ASSISTANCE® Program at any time, without further notice.

PATIENT CERTIFICATION AND CONSENT STATEMENT

Under this program, Allergan agrees to ship product to the sponsor for OZURDEX® (dexamethasone intravitreal implant) 0.7 mg for patients who have met the requirements set forth by the OZURDEX PATIENT ASSISTANCE® Program. All of the terms and conditions below must be met in order for a patient to be enrolled in the program.

- Patient must meet the eligibility criteria
- Sponsor must sign the application.
- Patient must complete and sign the application and provide income documentation.
- Patient must complete and sign the attached HIPAA authorization form.

I understand that this patient assistance program provides OZURDEX® at no charge and does not include the provider administration fee.
I verify that the information provided in this application is complete and accurate to the best of my knowledge and may be used by Allergan, Inc. and/or its agent or authorized designee in determining eligibility to participate in the OZURDEX PATIENT ASSITANCE® Program. I understand that at such time as I obtain coverage or have the financial resources to pay for the cost of therapeutic OZURDEX®, I will notify Allergan of such a change in my coverage status. I understand that I will be re-evaluated for eligibility for the OZURDEX PATIENT ASSISTANCE® Program every 12 months.

I also understand that Allergan, Inc. reserves the right to modify or discontinue the OZURDEX PATIENT ASSISTANCE® Program at any time without further notice.

ADDITIONAL OZURDEX® INFORMATION

☐ Yes, I am interested in receiving additional information about OZURDEX®.

☐ No, I am not interested in receiving additional information about OZURDEX®.

Patient's Signature (required)

Date Signed (required)

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HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF PATIENT INFORMATION

I authorize my physician, _____ ("Physician") to give Allergan, Inc., any subcontractors or agents of Allergan, Inc. ("Allergan") information about me which is necessary to determine my eligibility for the OZURDEX PATIENT ASSISTANT Program ("Program"), to administer the Program and to account for my withdrawal should I decide to stop participating in the Program. I understand that the type of information that can be given under this authorization may include my name, birth date, address, telephone number, social security number, income, prescription coverage, prescription for medication(s), financial documents and insurance records. I further understand that if my information is incomplete or the completed information does not allow me to participate in the Program that I may be notified of such by Allergan. I also understand that signing this authorization does not guarantee that I will be accepted into the Program. I further understand that because Allergan is not covered by federal privacy regulations, after my information is disclosed to Allergan, it will no longer be protected under federal law and could be subject to re-disclosure. This authorization will expire one (1) year after the date it is signed below, or one (1) year after the last date I receive medications under the Program, whichever is later. I may cancel this authorization at any time by providing written notice to Allergan at the address set forth below. My revocation will become effective on the date my written notice is received and processed by the Program and at such time I will no longer be qualified to receive medication assistance from the Program. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment from my Physician, but that I will not be able to participate in the Program.

You are entitled to a copy of this authorization for your records.

_____ _____

Signature of patient or authorized person Date

_____

Relationship/Reason patient is unable to sign