ELIGIBILITY ATTESTATION FORM

REQUEST FOR REPLACEMENT OF UNUSABLE PRODUCT

Dextenza®
(dexamethasone ophthalmic insert) 0.4 mg
for intracanalicular use

If a DEXTENZA insert is deemed unusable (per the attestment statement below)*, Ocular Therapeutix™ may send a replacement product via the OcuCare™ program.

- Please complete this form in its entirety and fax to OcuCare at **1-855-518-7564**.
- The physician/provider must sign the attestation.
- The replacement process must be initiated within 30 days of incident.
- FOR RETURNS OF EXPIRED PRODUCT OR PRODUCT DAMAGED IN SHIPMENT, please contact your distributor for return.
- Contact OcuCare at **1-877-286-2207** if you have any questions or need additional information on program eligibility.
- Product replacement is subject to adherence to Ocular Therapeutix policies and procedures regarding product replacement and Ocular Therapeutix right, in its sole discretion, to deny replacement when misuse is suspected.

PHYSICIAN/PROVIDER INFORMATION:

Today's Date: _____ Date of Incident: _____

Inserter Provider Name: _____ Signing Provider Name: _____

Inserting Provider Identifier (NPI): _____ Signing Provider Identifier (NPI#): _____

Signing Provider State License #: _____

Facility Name: _____ Facility City: _____

Facility Address: _____ Facility State: _____ Zip Code: _____

Facility State License #: _____

Contact Name: _____ Contact Email: _____

Contact Phone: _____ Contact Fax: _____

*ATTESTMENT STATEMENT:

I, _____ (Signing Provider Name), hereby attest that DEXTENZA is not usable due to reason(s) below; **with quantity listed in box**:

- ☐ Hydration before patient insertion (swelling)
- ☐ Mishandling or dropping
- ☐ Pouch being mishandled or damaged
- ☐ Temperature not being maintained at 2-8° C (36-46° F)
- ☐ Missing product in the pouch
- ☐ Other (Please provide explanation): _____
- ☐ **Total Unusable Units**

Delivery Address: Please provide the complete address where replacement product should be shipped: _____

DEXTENZA PRODUCT INFORMATION:

Lot # _____ Lot # _____ Lot # _____

Lot # _____ Lot # _____ Lot # _____

☐ Additionally, I attest that this product was purchased for an FDA-approved indication, was never administered to a patient, and furthermore, no reimbursement will be sought for the damaged product or use of the damaged product.

☐ I certify the product will be destroyed in accordance with federal and state regulations. (Product return not required)

By signing this form, I attest that this information is true, accurate and complete to the best of my knowledge.

I confirm that by signing this form, I am licensed to practice at the requested shipment location.

Provider Signature: _____

For an attestation statement to be valid and product to be replaced, the signature of the ordering/performing provider is required.

Phone: 1-877-286-2207 | **Fax:** 1-855-518-7564 | **www.DEXTENZA.com**

OcuCare™
PATIENT ACCESS AND REIMBURSEMENT SERVICES