

ELIGIBILITY ATTESTATION FORM

REQUEST FOR REPLACEMENT OF UNUSABLE PRODUCT

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

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

- **The physician/provider must sign the attestation.**
- Please complete this form in its entirety and fax to OcuCare at **1-855-518-7564**.
- 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:

Date of Incident:		Signing Provider Name:	
Insertor Provider Name:		Signing Provider Identifier (NPI#):	
Insertor Provider Identifier (NPI):		Signing Provider State License #:	
Facility Name:		Facility City:	
Facility Address:		Facility State:	Zip Code:
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 provided.**

Reason for Return	Quantity
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 Quantity Requested	

*REQUIRED 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: Today's Date:

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**