Request for Replacement of Unusable Product

ELIGIBILITY ATTESTATION FORM

For Use with 6+ Product Units ONLY

If a DEXTENZA insert is deemed unusable (per the attestment statement below)*, Ocular Therapeutix may send a replacement product via the DEXTENZA360 program.

- Please complete this form in its entirety and fax to **DEXTENZA360** 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 **DEXTENZA360** at **1-800-339-8369 Option 4** 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.

Today's Date: _____ Date of Incident: _____

Inserting 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 (total should be 6 or more):

- ☐ 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/description below)

_____

Delivery Address:

_____

Please provide the complete address where replacement product should be shipped.

DEXTENZA Product Information:

Total Unusable Units: _____

Lot # _____ Lot # _____ Lot # _____

Lot # _____ Lot # _____ Lot # _____

☐ 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.

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

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

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

Dextenza 360™
Patient Access and Reimbursement Services