DURYSTA®
(bimatoprost intracameral implant) 10 mcg

Allergan EyeCue®

Submit at: AllerganEyeCue.com
Call: 1-833-DURYSTA, option 2
Fax: 1-866-676-4069
Hours of operation: Mon-Fri, 9 AM-8 PM ET

*Required information

DURYSTA® SAVINGS PROGRAM PHYSICIAN REIMBURSEMENT REQUEST FORM

Thank you for using the DURYSTA® Savings Program. In order to receive reimbursement, you must submit this form within **180 days** from date of service by uploading to AllerganEyeCue.com or by faxing it, along with the required supporting documentation listed at the bottom of this page, to **1-866-676-4069**. If your patient qualifies, estimated time for reimbursement is 3 days (ACH) or 2 to 4 weeks (check).

PATIENT

Patient first name*:_____ Patient last name*:_____ Date of birth*:____/____/____

Patient Member ID*:_____

This is the number you receive after enrollment.

PHYSICIAN

Reimbursement checks will be mailed to the address on the Explanation of Benefits (EOB); not applicable to ACH payment.

Physician first name*:_____ Physician last name*:_____

Office contact email address*:_____

For fax users only: Please indicate payment preference type for claims reimbursement†:

☐ Electronic payment via ACH ☐ Check

†Note: Registered portal users with an indicated payment preference in their account profile will receive reimbursement based on the selected method.

SUPPORTING DOCUMENTS TO INCLUDE

- Completed DURYSTA® Savings Program Physician Reimbursement Request form (this form)
- HCFA 1500 form
- EOB document(s): Should be obtained from the patient's insurer

ATTESTATION

I, _____,
Physician's or delegate's name*

hereby attest that I am the prescribing physician or a delegate authorized to sign on behalf of the prescribing physician and that the patient listed above, on _____, received a DURYSTA® administration as a part of
Date of service*

the DURYSTA® Savings Program from Allergan, an AbbVie company. I also attest that, to the best of my knowledge, the patient listed above has not had a prior administration of DURYSTA® in the treated eye. I also attest that all appropriate steps were completed to determine the appropriate out-of-pocket cost for my patient and that the information submitted to *Allergan EyeCue*® is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of data may be subject to certain fines and/or liabilities. I understand that this information will be used for operational purposes as part of the DURYSTA® Savings Program.

PHYSICIAN OR DELEGATE SIGNATURE (REQUIRED)

Physician or delegate signature* _____ **Date*** _____

Complete and upload all materials to AllerganEyeCue.com or fax to 1-866-676-4069.
Questions? Contact our Help Desk at 1-833-DURYSTA, option 2 or visit AllerganEyeCue.com.

IMPORTANT INFORMATION: By submitting this form, you certify that you are not seeking reimbursement under any federal, state, or other government program for this prescription for DURYSTA®, a product of Allergan, an AbbVie company, and that you and the patient listed herein agree to comply with the DURYSTA Savings Program Terms, Conditions, and Eligibility Criteria available and printable at www.DurystaSavingsProgram.com. AbbVie, its affiliates, collaborators, and agents ("AbbVie") will use the information collected about you and your patient to provide and manage *Allergan EyeCue*® services and the DURYSTA Savings Program and to perform research and analytics on a de-identified basis. For more information about the categories of personal information collected by AbbVie and the purposes for which AbbVie uses personal information, visit www.abbvie.com/privacy. **Please share this information with your patient.**

Allergan an AbbVie company

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