OCULAR THERAPEUTIX

Retina experience redefined

MEDICAL AFFAIRS

Medical Information Request Form

Ocular Therapeutix Representative Contact Information

Name: _____ Phone: _____

Email: _____ Region/Territory: _____

Healthcare Professional Contact Information

Name: _____ Title: _____

Hospital Affiliation: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

Inquiry Details

Product: Select a product...

Inquiry Text:

Delivery: Select a delivery option... Rush Delivery: YES ☐ NO ☐

Digital Signature:

☐ I understand that checking this box constitutes my legal signature certifying that, this is an unsolicited request for medical information by a healthcare professional, and that the request is captured as the healthcare professional has intended.

Instructions:

1) Adverse events or product quality complaints should not be reported using this form.
2) Please complete all fields of the form.
3) Email the completed form to **ocutx.medinfo@propharmagroup.com**.

Corporate Headquarters: 15 Crosby Drive, Bedford, MA 01730 | 781 357 4000 | medicalaffairs@ocutx.com