Restasis MultiDose®
(Cyclosporine Ophthalmic Emulsion) 0.05%

Savings Card Reimbursement Form

If your mail-order pharmacy or pharmacy does not accept your savings card, you can mail in the necessary information to receive your savings. Print out the form here, complete it, and mail it, along with the other requested paperwork and proper postage, to the address listed.

Once we receive your completed claim form, we will mail you the check for your savings card reimbursement. You should receive it within 3 to 6 weeks.

Your savings card reimbursement check amount for *RESTASIS MultiDose*® or RESTASIS® (Cyclosporine Ophthalmic Emulsion) 0.05% will vary according to refill quantity and personal healthcare insurance coverage. After receiving your savings card reimbursement check, you may have paid, or be responsible for, some out-of-pocket costs. Please review the savings card program guidelines to learn about savings eligibility at https://www.restasis.com/savings-and-support/get-savings.

If you have any questions, please feel free to call us at 1-844-469-8327, option 3.

Thank you,
RESTASIS MultiDose® Patient Support

Mail this completed form to the address below. You must include your mail-order pharmacy invoice(s) received with the prescription, which should include:

1. Patient Name and Address
2. Pharmacy Name, Address, Phone
3. Prescription # or Rx #, Fill Date, Drug Name, Strength, NDC #
4. Quantity, Price, and/or Co-pay Amount Paid

Note: Only pharmacy invoice(s) are acceptable.

Name

Address

City

State ZIP Phone

E-mail Address

Date of Birth (MM/DD/YYYY) Gender

Savings Card ID#

Savings Card GRP#

MAIL TO

***RESTASIS MultiDose*® Claims Processing Department**
PO Box 2355, Morristown, NJ 07962

Allergan