PROVIDER LOCATOR AGREEMENT

ILUVIEN®
(fluocinolone acetonide intravitreal implant) 0.19mg

Terms of Participation

Your name, address and other information that you provide to us will be used by Alimera Sciences, Inc. ("Alimera") and the companies working with Alimera, pursuant to which your information may be made available to other healthcare providers, patients and consumers who wish to access your services. In order to be included within the ILUVIEN (fluocinolone acetonide intravitreal implant) 0.19 mg Provider Locator as a Healthcare Provider, you must be validly licensed (as required by state or federal law) and meet all of the following criteria: (A) Be able and willing to write prescriptions for pharmaceutical products, (B) Experienced in prescribing ILUVIEN and (C) Accepting new patients, provided they meet the requirements of your practice (e.g., accepted insurance types, etc.). You acknowledge that you received, read and understand the full Prescribing Information for ILUVIEN, including the directions for administration and use of the product. You are fully and solely responsible for the quality of care to be provided at your site of care.

We may contact you by e-mail, postal mail or telephone to verify and update your profile, notify you as to any changes in eligibility criteria and assess your continued eligibility for the Provider Locator.

Alimera will not share your information with anyone else except as described above or as required by law. Inclusion of your name and organizational information as part of our Provider Locator does not represent, and will not necessarily result in, any endorsement, referral or recommendation by Alimera and your agreement to be listed in the Provider Locator shall not be construed as an inducement or encouragement for the referral of patients or use of particular products. If you want to stop receiving this information, you may ask us to remove you from our contact list by calling 1-844-445-8843 .

PRIMARY FACILITY:

Name of Primary Practice/Facility _____

Phone (_____) _____ Fax (_____) _____

Address_____ City_____ State_____ Zip _____

Facility Website _____ DEA #_____ NPI # _____ ME # _____

Email _____ Best Time to Call _____

Hours that site is open: M_____ T_____ W_____ Th_____ F _____ Sat _____ Sun _____

Is your practice accepting new patients for the treatment of diabetic macular edema? ☐ Yes ☐ No

Accepted Insurance Types: ☐ Most private health plans, most public health plans ☐ Most private health plans, no public health plans
☐ Most public health plans, no private health plans

PRIMARY HEALTH CARE PROVIDER:

Name of Primary Provider at the Above Facility _____

Does the primary provider at this facility also have a secondary facility? ☐ Yes ☐ No (If yes, please complete side 2 of this form.)

Are there secondary health care providers at the above facility? ☐ Yes ☐ No (If yes, please complete side 2 of this form.)

By signing below, I hereby certify that I have read and agree to comply with the terms of participation set forth above. If at any time Alimera determines the applicable Healthcare Provider criteria are not met, Alimera may remove my name and related facilities from this program. The undersigned is the above-named provider, or if I am signing on behalf of a facility, I certify that I am authorized to do so.

Name/Title (please print) _____

Signature _____ Date of Signature_____

Alimera reserves the right to alter or discontinue this program at our discretion.

FOR ADDITIONAL HEALTH CARE PROVIDERS AND ADDITIONAL FACILITIES, PLEASE SEE PAGE 2 FOR MORE INFORMATION

Please return this completed form (pages 1 & 2) via fax to: 1-404-521-4326 or call 1-844-445-8843 with any questions.
PLEASE SEE PRESCRIBING INFORMATION AT ILUVIEN.COM.

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ADDITIONAL HEALTH CARE PROVIDER AND FACILITY INFORMATION:

ADDITIONAL FACILITY:

Name of Secondary Practice/Facility _____

Phone (_____) _____ Fax (_____) _____

Address _____ City _____ State _____ Zip _____

Facility Website _____ DEA # _____ NPI # _____ ME # _____

Email _____ Best Time to Call _____

Hours that site is open: M _____ T _____ W _____ Th _____ F _____ Sat _____ Sun _____

Is your practice accepting new patients for the treatment of diabetic macular edema? ☐ Yes ☐ No

Accepted Insurance Types: ☐ Most private health plans, most public health plans ☐ Most private health plans, no public health plans
☐ Most public health plans, no private health plans

ADDITIONAL PROVIDER 1:

Name of secondary health care provider _____

Facility name of secondary provider _____

By signing below, I hereby certify that I have read and agree to comply with the terms of participation set forth above. The undersigned is the above-named provider, or if I am signing on behalf of a facility, I certify that I am authorized to do so.

Name/Title (please print) _____

Signature _____ Date of Signature _____

ADDITIONAL PROVIDER 2:

Name of secondary health care provider _____

Facility name of secondary provider _____

By signing below, I hereby certify that I have read and agree to comply with the terms of participation set forth above. The undersigned is the above-named provider, or if I am signing on behalf of a facility, I certify that I am authorized to do so.

Name/Title (please print) _____

Signature _____ Date of Signature _____

Please return this completed form (pages 1 & 2) via fax to: 1-404-521-4326 or call 1-844-445-8843 with any questions.

PLEASE SEE PRESCRIBING INFORMATION AT ILUVIEN.COM.

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