Draft Version – out of date as at 23 June 08

Lucentis®▼(ranibizumab) Dose Capping Scheme
Pharmacy Claim Form

Please indicate whether you are submitting a claim for **Replacement Stock/Credit Note/Refund** (circle as appropriate)

Replacement product/credit note or cash refund addressee/payee details:

……

Please complete a box for each vial for which reimbursement is claimed.

For the first claim (vial 15) please also send a copy of the pharmacy dispensing form.

Patient No………………………………………

Right Eye	**Left Eye**
Name of responsible person: ……………………………........ Signature: ...………………………………………..................... Date: …………………………………………………………….. **Vial 15 Batch No**……………………………………………….	Name of responsible person: ……………………………........ Signature: ...………………………………………..................... Date: …………………………………………………………….. **Vial 15 Batch No**……………………………………………….
Name of responsible person: ……………………………........ Signature: ...………………………………………..................... Date: …………………………………………………………….. **Vial 16 Batch No**……………………………………………..…	Name of responsible person: ……………………………........ Signature: ...………………………………………..................... Date: …………………………………………………………….. **Vial 16 Batch No**……………………………………………..
Name of responsible person: ……………………………........ Signature: ...………………………………………..................... Date: …………………………………………………………….. **Vial 17 Batch No**……………………………………………	Name of responsible person: ……………………………........ Signature: ...………………………………………..................... Date: …………………………………………………………….. **Vial 17 Batch No**…………………………………………….
Name of responsible person: ……………………………........ Signature: ...………………………………………..................... Date: …………………………………………………………….. **Vial 18 Batch No**……………………………………………	Name of responsible person: ……………………………........ Signature: ...………………………………………..................... Date: …………………………………………………………….. **Vial 18 Batch No**……………………………………………

Further information on the Lucentis Dose Capping Scheme is also available on www.lucentis.co.uk

LUCENTIS PRESCRIBING INFORMATION

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