



# Natrelle® Gel Free Bonus Gift Certificate New Enhanced 2011 Offer!

Here's how to get your **Natrelle®** Gel Bonus Gift.

- Bring this form when you visit your surgeon to discuss your **Natrelle®** Gel **breast augmentation** procedure and ask if Latisse® (bimatoprost ophthalmic solution) 0.03% is right for you.
- Ask your medical doctor\* for a prescription for Latisse® using this form.
- After surgery, fill in your name, address, city, state, zip, email address, phone number, and **Natrelle®** Gel Patient ID Card information.
- Ask your doctor's office to complete and fax this prescription form to **1-877-345-4395** or mail it to PO Box 587, Wayne, NJ 07474. Your free trial of Latisse®, \$20 Latisse® Rebate, and Four \$20 off Rebates for your friends, worth over \$150, will be mailed to you. (Please allow 7 to 10 days for delivery).

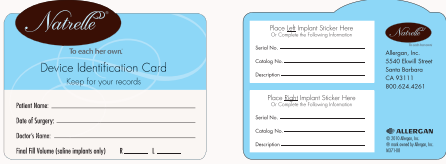
For assistance, call us at 1-877-345-4393.

Please print patient information.

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email \_\_\_\_\_  
 Phone \_\_\_\_\_

- I prefer not to receive future special offers, tips, and other information about Latisse® and other Allergan products.
- \*Medical doctor = MD, DO, and/or an OD (optometrist) from any state in the United States except CA, CO, DE, IL, MD, or VA.  
 \*\*Providing your email address will allow tracking information to be sent to you regarding your product shipment.

Not for refill. Limit only one kit per pair of **Natrelle®** Gel breast implants.  
Offer valid for breast augmentation occurring between 1/24/11 - 12/31/11, while supplies last.



### Patient ID Card Information

(L) Catalog No.: \_\_\_\_\_  
 (L) Serial No.: \_\_\_\_\_  
 (R) Catalog No.: \_\_\_\_\_  
 (R) Serial No.: \_\_\_\_\_  
 Surgery Date: \_\_\_\_\_

All fields are required in order for prescription to be valid.

Rx Latisse® (bimatoprost ophthalmic solution) 0.03%  
 Patient Date of Birth \_\_\_\_\_  
 Patient Allergies \_\_\_\_\_  
 Patient Health Conditions \_\_\_\_\_  
 Disp. State License No. \_\_\_\_\_  
 DEA No. \_\_\_\_\_  
 National Provider No. \_\_\_\_\_  
 Medical Doctor Name \_\_\_\_\_  
 Practice Name \_\_\_\_\_  
 Practice Phone No. \_\_\_\_\_

I certify this patient had an elective breast augmentation procedure that was not reimbursed or paid under Medicare, Medicaid, or any similar federal or state healthcare program.

Medical Doctor Signature \_\_\_\_\_

