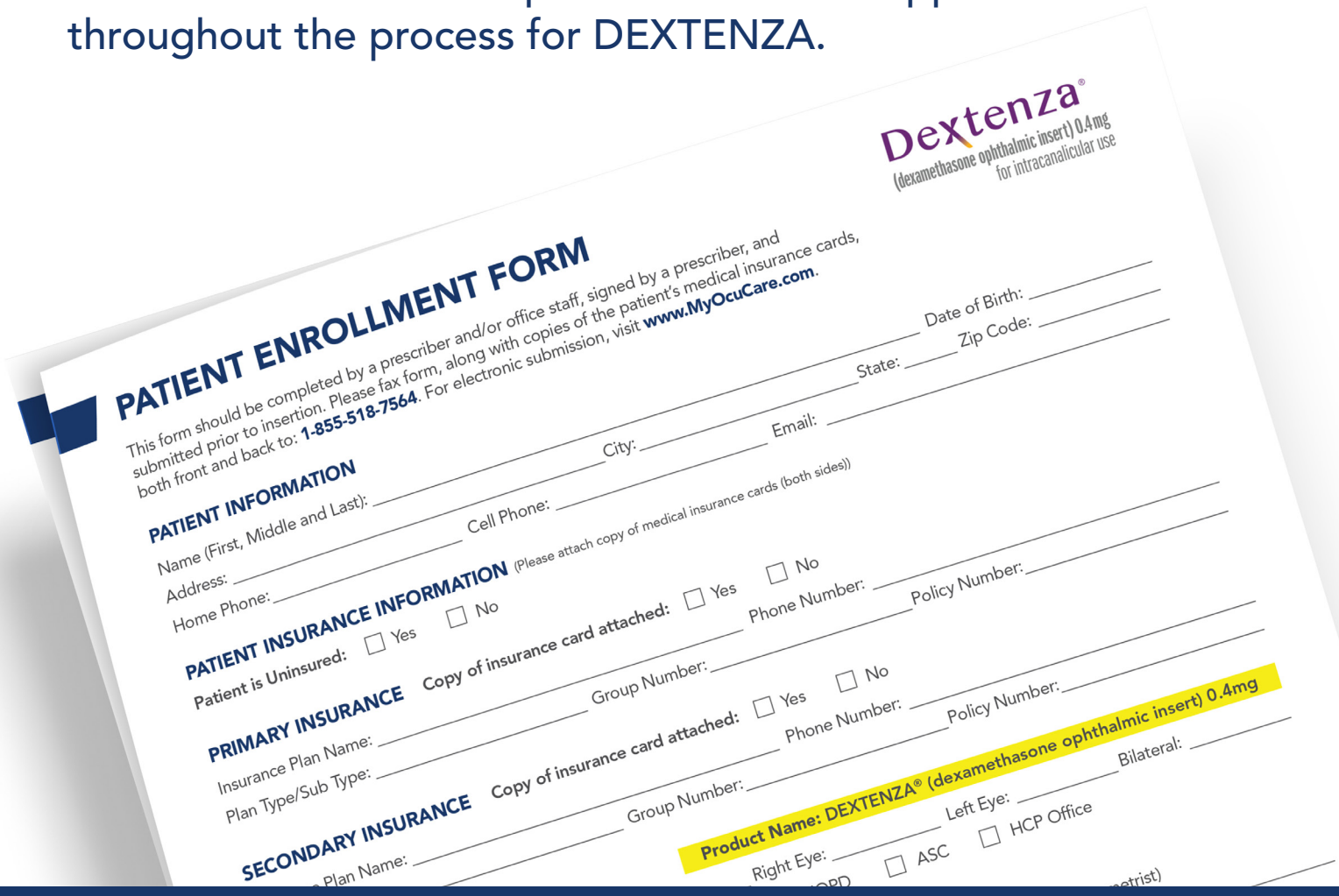
OcuCare™

PATIENT ACCESS AND REIMBURSEMENT SERVICES

Reimbursement Guidebook

This guide provides reimbursement information for DEXTENZA, including sample claim forms, and how OcuCare™ can provide seamless support throughout the process for DEXTENZA.



Click, Call, or Connect MyOcuCare.com

Dextenza®
(dexamethasone ophthalmic insert) 0.4mg
for intracanalicular use

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(dexamethasone ophthalmic insert) 0.4 mg
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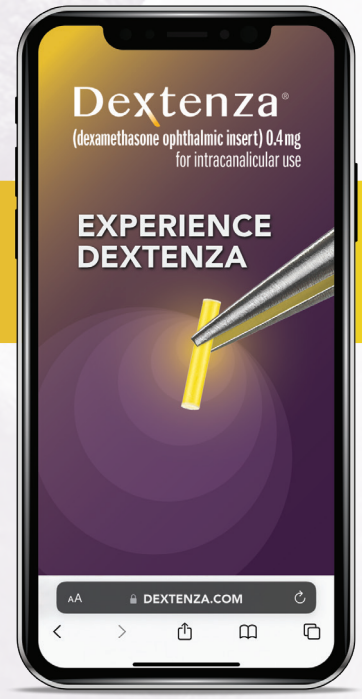

Connect to Us

www.DEXTENZA.com
www.MyOcuCare.com

www.x.com/OCUTX
www.x.com/DEXTENZA_

www.linkedin.com/company/ocular-therapeutix-inc
www.linkedin.com/showcase/dextenza/

Table of Contents

Click on page number to jump to page.

THE ROLE OF OCUCARE IN PATIENT ACCESS TO DEXTENZA

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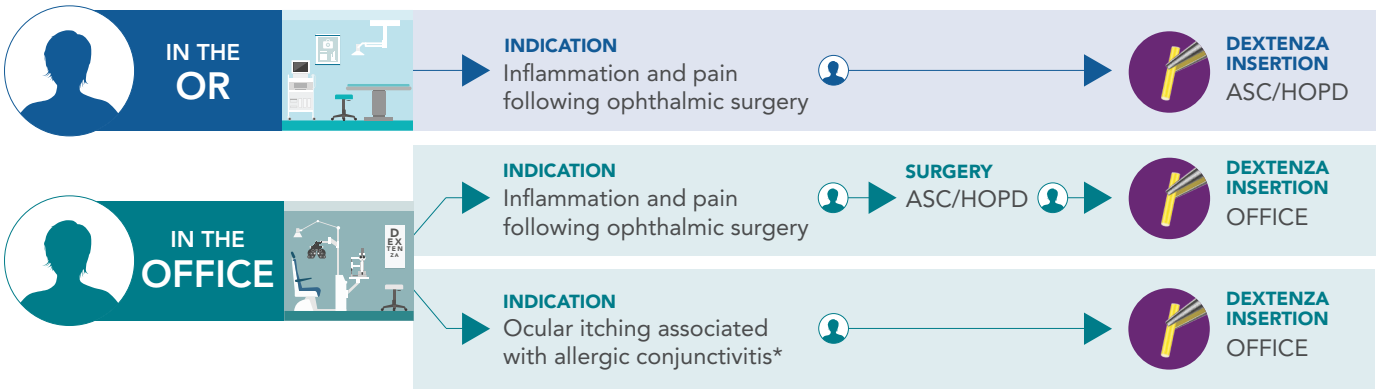
for intracanalicular use

DEXTENZA Patient Journey



Operating Room (OR), Ambulatory Surgery Center (ASC), Hospital Outpatient Department (HOPD)

*In adults and pediatric patients aged 2 years and older. Not recommended for ocular itching associated with allergic conjunctivitis in pediatric patients who require sedation for insertion.

Your Dedicated DEXTENZA Team

Your dedicated DEXTENZA team consists of a national account director, key account manager, medical director, OcuCare case manager, and field reimbursement manager. Our Medical Affairs team is also available to assist with any questions.

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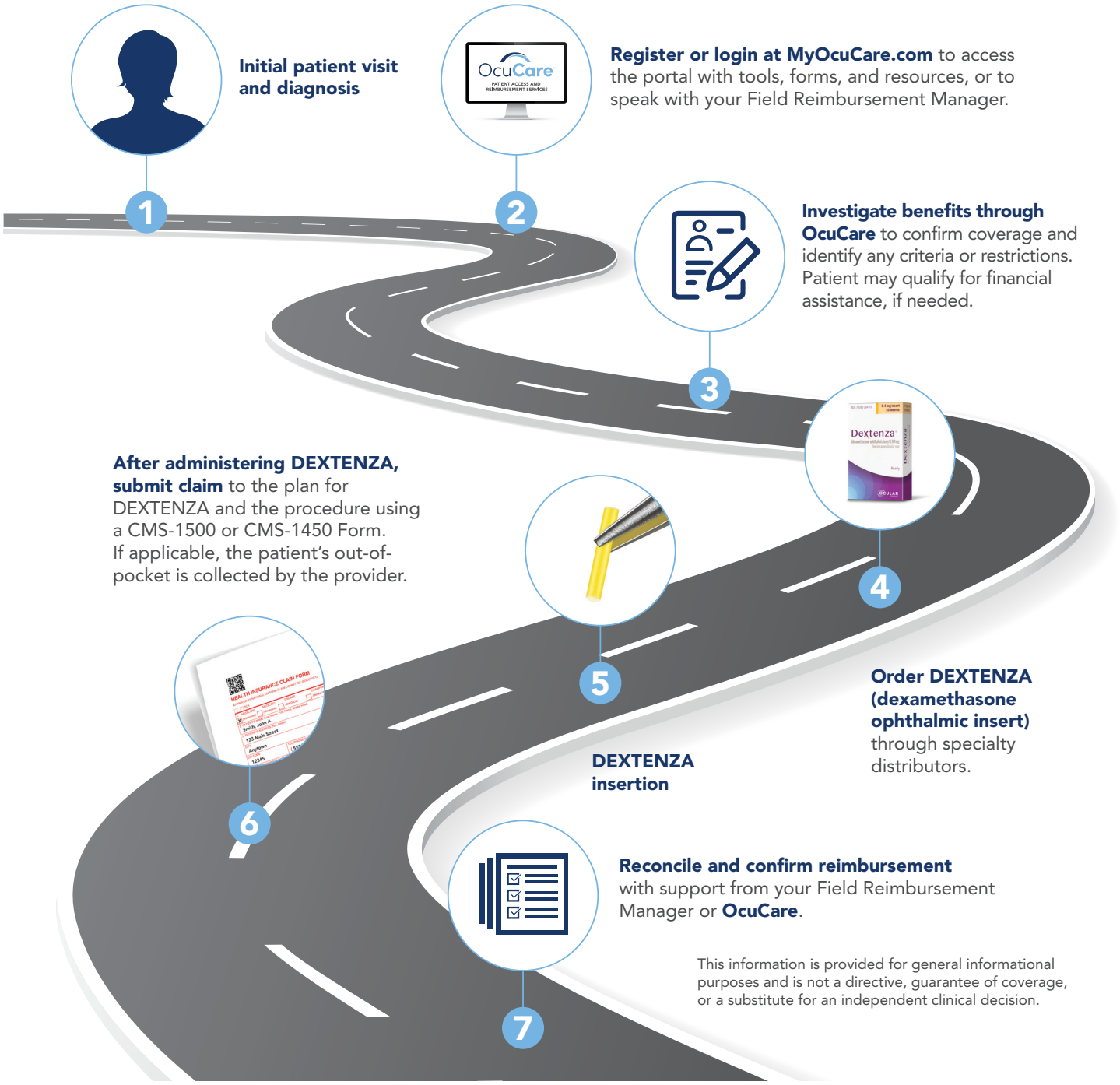
Reimbursement Roadmap

We recognize that every care setting is unique.
We support you and your team with your specific needs.



This information is provided for general informational purposes and is not a directive, guarantee of coverage, or a substitute for an independent clinical decision.

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PATIENT ACCESS AND REIMBURSEMENT SERVICES

Click here to return to Table of Contents

How to Order DEXTENZA

Contact one of our authorized distributors listed below to order DEXTENZA and receive it as soon as the next business day

DISTRIBUTOR	PHONE	FAX	WEBSITE
Besse Medical	1-800-543-2111	1-800-543-8695	www.besse.com
Cardinal Specialty Pharma Distribution	1-855-855-0708	1-614-553-6301	www.cardinalhealth.com/specialtyonline
FFF Enterprises	1-800-843-7477	1-800-418-4333	biosupply.fffenterprises.com
Henry Schein	1-800-772-4346	1-800-329-9109	www.henryschein.com/medical
Metro Medical	1-800-768-2002	1-615-256-4194	www.metromedicalorder.com
McKesson Medical-Surgical	1-855-571-2100	1-800-311-3408	mms.mckesson.com
McKesson Plasma & Biologics for Hospitals	1-877-625-2566	1-888-752-7626	connect.mckesson.com

Ocular Therapeutix does not recommend the use of any particular distributor.

Product	Active Ingredient	Quantity	10-Digit NDC* Number†	11-Digit NDC Number‡
DEXTENZA (dexamethasone ophthalmic insert) 0.4 mg	(dexamethasone USP)	1	70382-204-01	70382-0204-01
DEXTENZA (dexamethasone ophthalmic insert) 0.4 mg	(dexamethasone USP)	10	70382-204-10	70382-0204-10

*NDC = National Drug Code

†10-Digit NDC code as assigned by FDA, certain payers accept the 10 digit format.

‡11-Digit NDC code that can be utilized for payers that require 11 digits or when ordering product.

Storage and Handling

How DEXTENZA is supplied[1]

DEXTENZA is supplied sterile in a foam carrier within a foil laminate pouch:

- NDC 70382-204-01 Carton containing 1 pouch (1 inserts)
- NDC 70382-204-10 Carton containing 10 pouches (10 inserts)

Proper storage and handling[1]

- Do not freeze. Store refrigerated, between 2°C and 8°C (36°F and 46°F)
- Protect from light, keep in package until use
- Do not use if pouch has been damaged or broken
- DEXTENZA is intended for single dose only

1. DEXTENZA [package insert]. Bedford, MA: Ocular Therapeutix, Inc.; 2025.

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Product and Procedure Billing Codes

Product Reimbursement

DEXTENZA has separate payment† in the ASC and HOPD setting due to meeting criteria set forth in the non-opioid as a surgical supply provision by CMS.

Product Code	Description
J1096 J-code[1*]	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg

When submitting a claim, enter a unit of 4 for the DEXTENZA HCPCS code (J1096); the HCPCS descriptor for DEXTENZA is 0.1 mg.

As of July 1, 2023, Providers must report JZ modifiers[2] on Medicare Part B claims for single use drugs

Procedure Reimbursement

Procedure Code	Description
68841 CPT code[3‡]	Insertion of drug-eluting implant including punctal dilation when performed, into lacrimal canaliculus, each

Customers are responsible for determining the appropriate coding and submission of accurate claims.

* A permanent code used to report non–orally administered drugs that cannot be self-administered. May be accompanied by a procedure-based CPT code.

† Medicare Advantage (Part C) and Commercial plans may or may not follow Medicare recommendations in making coverage decisions. Payment rates may vary per facility contracts.

‡ CPT® is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®), an alphanumeric coding system maintained by the American Medical Association to identify medical services and procedures provided by physicians and other healthcare professionals.

References: 1. MedicalBillingAndCoding.org. Everything You Need to Get Started in Medical Billing & Coding. https://medicalbillingandcoding.org/hcpcs-codes/. Accessed June 4, 2026. **2.** Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/mm13056-new-jz-claims-modifier-certain-medicare-part-b-drugs.pdf. Accessed Accessed June 4, 2026. **3.** MedicalBillingAndCoding.org. Intro to CPT Coding. https://medicalbillingandcoding.org/intro-to-cpt/. Accessed June 4, 2026.

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ICD-10 Codes

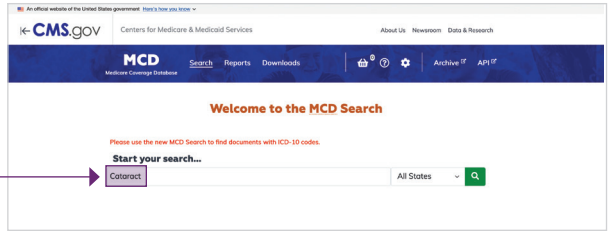
ICD§-10 Code Identification

- When billing for DEXTENZA (J1096), the diagnosis code (ICD-10)‖ should align with the primary procedure
- CMS's Medicare Coverage Database (MCD) Search is a resource that supports the identification of appropriate ICD-10 codes for the primary procedure.

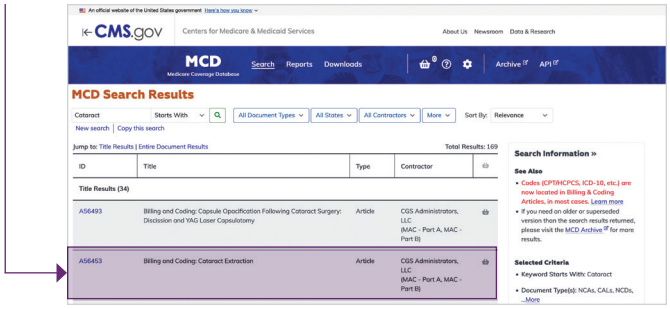
https://bit.ly/MCDsearch

CMS's MCD Search

- Access link
- Type in Cataract or another ophthalmic surgery in search field



- Pick the appropriate Medicare Administrative Contractor (MAC) and description
- On the next page, scroll down and select the appropriate ICD-10 codes



This may not be a complete list of ICD-10 codes, visit **www.cms.gov/medicare/coding/medhcpcsgeninfo** for all codes.

Customers are responsible for determining the appropriate coding and submission of accurate claims.

National Drug Codes (NDC)

Product	Active Ingredient	Quantity	10-Digit NDC Number	11-Digit NDC Number
DEXTENZA (dexamethasone ophthalmic insert) 0.4 mg	(dexamethasone USP)	1	70382-204-01‖	70382-0204-01
DEXTENZA (dexamethasone ophthalmic insert) 0.4 mg	(dexamethasone USP)	10	70382-204-10‖	70382-0204-10

* A permanent code used to report non-orally administered drugs that cannot be self-administered. May be accompanied by a procedure-based CPT code.
† Medicare Advantage (Part C) and Commercial plans may or may not follow Medicare recommendations in making coverage decisions. Payment rates may vary per facility contracts.
‡ CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT), an alphanumeric coding system maintained by the American Medical Association to identify medical services and procedures provided by physicians and other healthcare professionals.
§ International Classifications of Diseases (ICD).
‖ 10-Digit NDC code as assigned by FDA, certain payers accept the 10-digit format.

References: 1. Federal Register. https://www.federalregister.gov/documents/2024/11/27/2024-25521/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical. Accessed Accessed June 4, 2026. **2.** Centers for Medicare & Medicaid Services. https://www.cms.gov/files/document/mm13056-new-jz-claims-modifier-certain-medicare-part-b-drugs.pdf. Accessed Accessed June 4, 2026. **3.** MedicalBillingAndCoding.org. Intro to CPT Coding. https://medicalbillingandcoding.org/intro-to-cpt/. Accessed June 4, 2026.

Possible Applicable Modifiers

Clinical diagnosis and coding are at the discretion of the healthcare provider. Information provided below is for reference of possible applicable modifiers.

This may not be a complete list of modifiers.
For more information about applicable modifiers, **visit https://bit.ly/MCDsearch**.

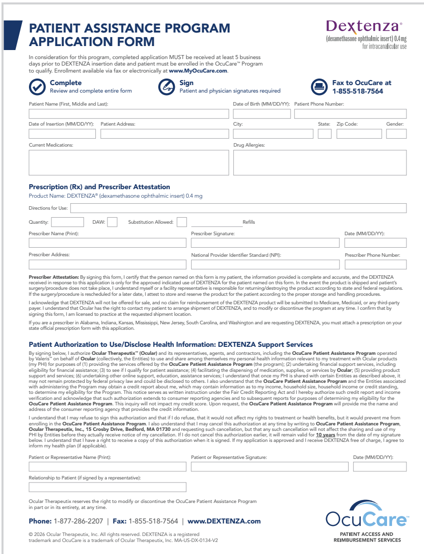
Possible Applicable Modifiers

Description	Modifier
Left side (used to identify procedures performed on the left side of the body)	LT
Right side (used to identify procedures performed on the right side of the body)	RT
Bilateral (used to identify procedures performed on both sides of the body during the same operative session)	50
Upper left, eyelid	E1
Lower left, eyelid	E2
Upper right, eyelid	E3
Lower right, eyelid	E4
Staged or Related Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period	58
Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Healthcare Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	78
Unrelated Procedure by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period	79
Zero drug amount discarded/not administered to any patient. This modifier should only be used for drugs or biologicals that are single use vials or packages.	JZ

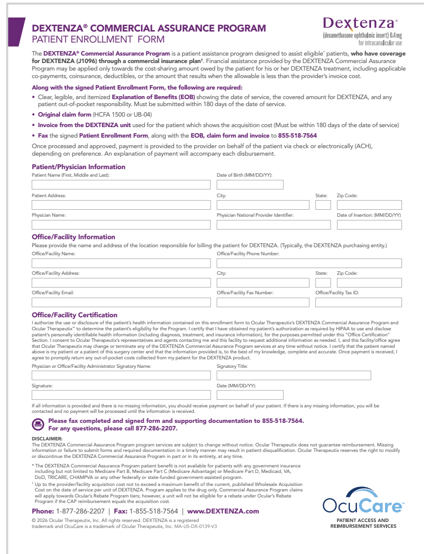
TIP TO REMEMBER

Customers are responsible for determining the appropriate coding and submission of accurate claims.

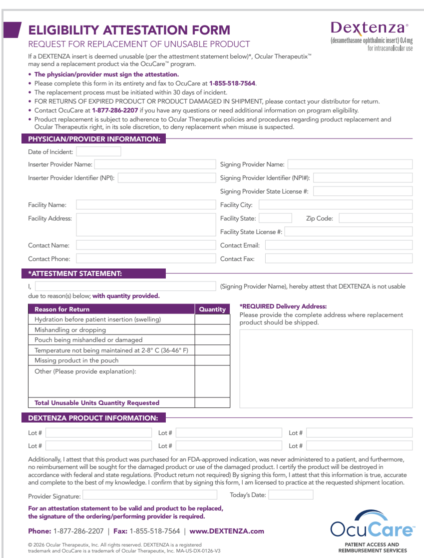
Find more information about HCPCS codes at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update



PATIENT ASSISTANCE PROGRAM (PAP)



COMMERCIAL ASSURANCE PROGRAM (CAP)



PRODUCT REPLACEMENT PROGRAM

Information on all these programs is available on **www.DEXTENZA.com** or **www.MyOcuCare.com**

Patient Assistance Program (PAP) Application Information

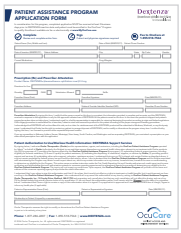
Patients without health insurance may be eligible to receive DEXTENZA free of charge, including patients who do not have drug coverage for DEXTENZA. You or your patient may submit an application to the DEXTENZA Patient Assistance Program.

To be eligible, a patient must be a U.S. resident, and have an annual income <500% of the Federal Poverty Level (FPL), adjusted for family size.

ACTION STEPS

The following steps are required for your free DEXTENZA to arrive in time for your procedure.

1 — **Complete and return form**


PATIENT ASSISTANCE PROGRAM
APPLICATION FORM

2 — **Receive approval letter in the mail**

If approved for a free DEXTENZA, you and your patient will be notified by OcuCare via mail and fax, respectively. Watch for this letter in the mail.

3 — **Connect with the OcuCare pharmacist**

In order to receive your free DEXTENZA, your patient will be required to speak to the dispensing pharmacist. Please advise your patient to answer the call or to return the call to **877-286-2207** as soon as possible.

Note: Caller ID will display OcuCare and 1-877-286-2207.

Your patients DEXTENZA prescription will be filled free of charge and shipped directly to the insertion site prior to your scheduled insertion date.

NOTE: Please advise your patient to inform their health plan (if applicable) that you have received DEXTENZA free of charge.

Ocular Therapeutix reserves the right to modify or discontinue the DEXTENZA Patient Assistance Program in part or in its entirety, at any time. Free product is contingent upon program eligibility requirements.

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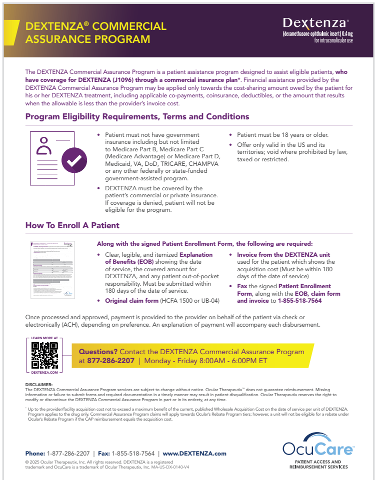
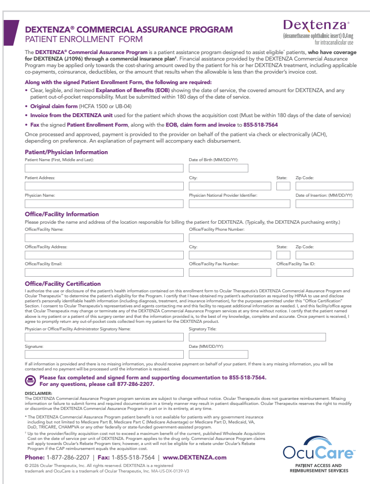
Commercial Assurance Program (CAP) Overview and Criteria



The DEXTENZA Commercial Assurance Program is a patient assistance program designed to assist eligible* patients, **who have coverage for DEXTENZA (J1096) through a commercial insurance plan**†. Financial assistance provided by the DEXTENZA Commercial Assurance Program may be applied only towards the cost-sharing amount owed by the patient for his or her DEXTENZA treatment, including applicable co-payments, coinsurance, deductibles, or the amount that results when the allowable is less than the provider's invoice cost.

Program Eligibility Requirements

- Patient must not have government insurance including but not limited to Medicare Part B, Medicare Part C (Medicare Advantage) or Medicare Part D, Medicaid, VA, DoD, TRICARE, CHAMPVA or any other federally or state-funded government-assisted program.
- DEXTENZA must be covered by the patient's commercial or private insurance. If coverage is denied, patient will not be eligible for the program.
- Patient must be 18 years or older.
- Offer only valid in the US and its territories; void where prohibited by law, taxed or restricted.



Along with the signed Patient Enrollment Form, the following are required:

- Clear, legible, and itemized **Explanation of Benefits (EOB)** showing the date of service, the covered amount for DEXTENZA, and any patient out-of-pocket responsibility. Must be submitted within 180 days of the date of service.
- **Original claim form** (HCFA 1500 or UB-04)
- **Invoice from the DEXTENZA unit** used for the patient which shows the acquisition cost (Must be within 180 days of the date of service)
- **Fax** the signed **Patient Enrollment Form**, along with the **EOB, claim form and invoice** to **1-855-518-7564**

Once processed and approved, payment is provided to the provider on behalf of the patient via check or electronically (ACH), depending on preference. An explanation of payment will accompany each disbursement.

DISCLAIMER:
The DEXTENZA Commercial Assurance Program program services are subject to change without notice. Ocular Therapeutix does not guarantee reimbursement. Missing information or failure to submit forms and required documentation in a timely manner may result in patient disqualification. Ocular Therapeutix reserves the right to modify or discontinue the DEXTENZA Commercial Assurance Program in part or in its entirety, at any time.

* The DEXTENZA Commercial Assurance Program patient benefit is not available for patients with any government insurance including but not limited to Medicare Part B, Medicare Part C (Medicare Advantage) or Medicare Part D, Medicaid, VA, DoD, TRICARE, CHAMPVA or any other federally or state-funded government-assisted program.

† Up to the provider/facility acquisition cost not to exceed a maximum benefit of the current, published Wholesale Acquisition Cost on the date of service per unit of DEXTENZA. Program applies to the drug only. Commercial Assurance Program claims will apply towards Ocular's Rebate Program tiers; however, a unit will not be eligible for a rebate under Ocular's Rebate Program if the CAP reimbursement equals the acquisition cost.

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Dextenza®
(dexamethasone ophthalmic insert) 0.4 mg
for intracanalicular use

Product Replacement Program Overview and Criteria

If a DEXTENZA® insert is deemed unusable, Ocular Therapeutix may send a replacement product via the OcuCare™ program.

FOR RETURNS OF EXPIRED PRODUCT OR PRODUCT DAMAGED IN SHIPMENT, please contact your distributor for return.

DEXTENZA Replacement Process:

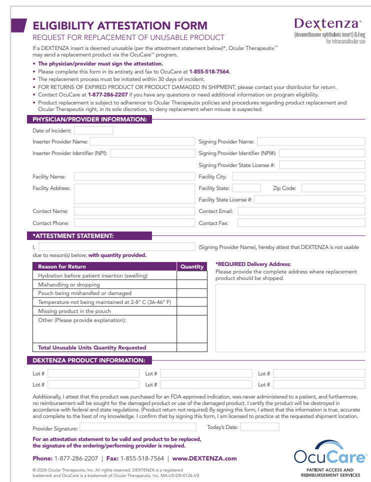
1. **VISIT www.DEXTENZA.com** or **www.MyOcuCare.com** or **PHONE 877-286-2207** to request a form.

2. **COMPLETE, SIGN,** and **FAX** the **Product Replacement Form** to **1-855-518-7564** or upload via the OcuCare HCP portal at **www.MyOcuCare.com.**

3. Physician/facility must provide a description of the incident and/or damage and properly dispose of spoiled/damaged DEXTENZA with documented attestment of doing so. The replacement process must be initiated within 30 days of spoilage/damage.

4. Once the Product Replacement Form is received and approved, customer should **RECEIVE** replacement product within 5-10 business days, shipped from Cardinal Health.

REPLACEMENT FORM



ELIGIBILITY ATTESTATION FORM

REQUEST FOR REPLACEMENT OF UNUSABLE PRODUCT

Dextenza® (dexamethasone ophthalmic insert) 0.4 mg for intracanalicular use

If a DEXTENZA insert is deemed unusable (per the attestment statement below)*, Ocular Therapeutix™ may send a replacement product via the OcuCare™ program.

- **The physician/provider must sign the attestation.**
- Please complete this form in its entirety and fax to OcuCare at **1-855-518-7564**.
- The replacement process must be initiated within 30 days of incident.
- FOR RETURNS OF EXPIRED PRODUCT OR PRODUCT DAMAGED IN SHIPMENT, please contact your distributor for return.
- Contact OcuCare at **1-877-286-2207** if you have any questions or need additional information on program eligibility.
- Product replacement is subject to adherence to Ocular Therapeutix policies and procedures regarding product replacement and Ocular Therapeutix right, in its sole discretion, to deny replacement when misuse is suspected.

PHYSICIAN/PROVIDER INFORMATION:

Date of Incident:

Inserter Provider Name: Signing Provider Name:

Inserter Provider Identifier (NPI): Signing Provider Identifier (NPI#):

Signing Provider State License #:

Facility Name: Facility City:

Facility Address: Facility State: Zip Code:

Facility State License #:

Contact Name: Contact Email:

Contact Phone: Contact Fax:

***ATTESTMENT STATEMENT:**

I, (Signing Provider Name), hereby attest that DEXTENZA is not usable due to reason(s) below; **with quantity provided.**

Reason for Return	Quantity
Hydration before patient insertion (swelling)	
Mishandling or dropping	
Pouch being mishandled or damaged	
Temperature not being maintained at 2-8° C (36-46° F)	
Missing product in the pouch	
Other (Please provide explanation):	
Total Unusable Units Quantity Requested	

***REQUIRED Delivery Address:**
Please provide the complete address where replacement product should be shipped.

DEXTENZA PRODUCT INFORMATION:

Lot # Lot # Lot #

Lot # Lot # Lot #

Additionally, I attest that this product was purchased for an FDA-approved indication, was never administered to a patient, and furthermore, no reimbursement will be sought for the damaged product or use of the damaged product. I certify the product will be destroyed in accordance with federal and state regulations. (Product return not required) By signing this form, I attest that this information is true, accurate and complete to the best of my knowledge. I confirm that by signing this form, I am licensed to practice at the requested shipment location.

Provider Signature: Today's Date:

For an attestation statement to be valid and product to be replaced, the signature of the ordering/performing provider is required.

Phone: 1-877-286-2207 | **Fax:** 1-855-518-7564 | **www.DEXTENZA.com**

OcuCare™ PATIENT ACCESS AND REIMBURSEMENT SERVICES

PLEASE NOTE:

- The physician or provider must attest that the information provided is true, accurate and complete to the best of his/her knowledge.
- Product replacement is subject to adherence to Ocular Therapeutix policies and procedures and Ocular Therapeutix has the right, in its sole discretion, to deny replacement when misuse is suspected.

Product is deemed unusable if:

- The product was mishandled, dropped, or broken;
- The product was inappropriately stored, refrigerated, or frozen;
- The product is deemed not appropriate for administration before, during, or after the procedure.

Click here to return to Table of Contents

Comprehensive Support With OcuCare

YOU AND YOUR PATIENTS - AT THE CENTER OF OUR OCUCARE COMMITMENT

Benefits investigation

A full report, including insurance coverage, within 2 business days.

Claims assistance

Helping address your questions up front. Receive coding and billing guidance before a claim is submitted, claims assistance and support.

Prior authorization (PA) assistance

If a PA is necessary, we provide access to helpful forms and assistance with payer requirements to facilitate approval.

Appeal assistance

Individualized guidance on appeal submission and assistance with documentation and forms. We track the status of appeals and provide updates on the appeals process.

Patient financial assistance programs

Assistance for all qualifying patients. OcuCare will help determine patient eligibility and investigate options.

MAKING OCUCARE SUPPORT CONVENIENT FOR YOU

Click, Call, or Connect MyOcuCare.com

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MyOcuCare.com Portal

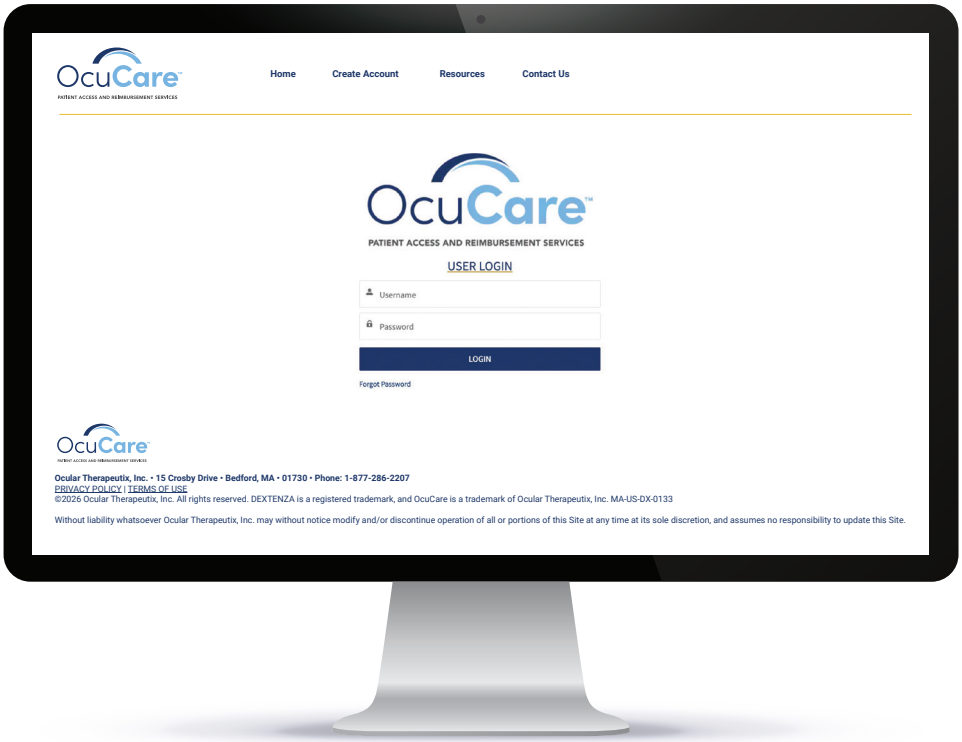
Create an account to seamlessly access your dedicated resource and support team.

All Programs are Available on the Portal

- Benefit Investigation Requests
- Commercial Assurance Program Enrollment Enrollment
- DEXTENZA Patient Assistance Program Enrollment
- Unusable Product Replacement Program Requests

New Functionality

- Enhanced Search Capabilities
- Reports
- Upload Documents
  - Insurance Cards
  - Unusable Product Replacement Program Forms
  - DEXTENZA Patient Assistance Program Applications
  - CAP Enrollments



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OcuCare Patient Enrollment Form

The support you need starts with this simple form. The **OcuCare Patient Enrollment Form** allows you to request a wide range of resources to support you and your DEXTENZA patients.

Important Reminders

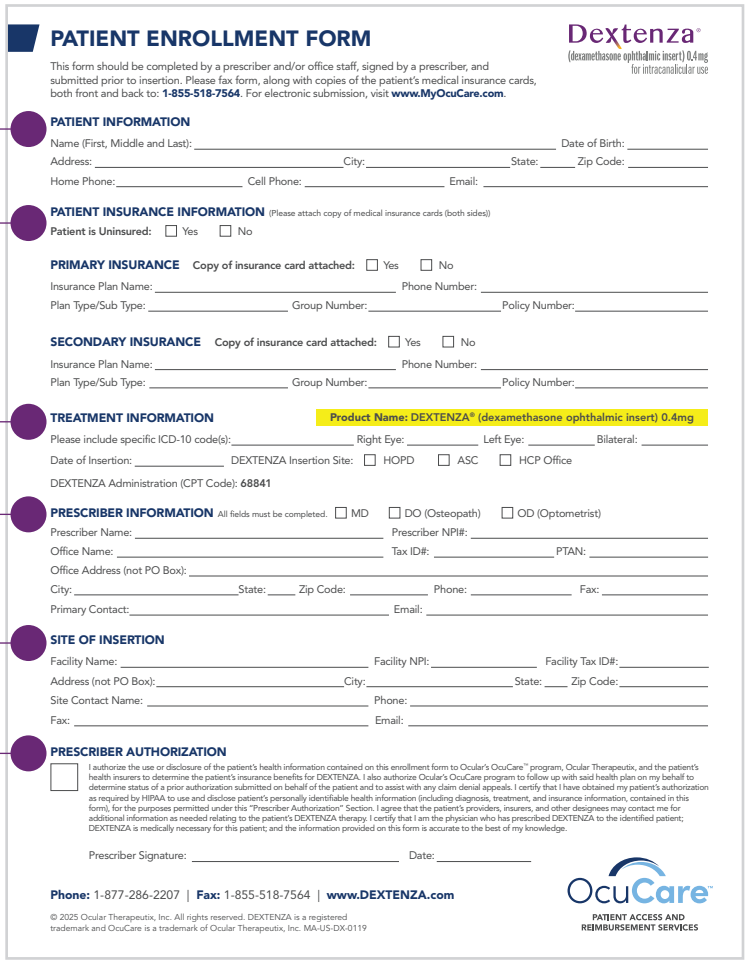
- Prescriber must sign
- Please send to OcuCare five (5) business days prior to insertion
- Can be faxed or sent electronically through the **MyOcuCare.com** portal*.

Provide patient and insurance information

Complete treatment information section

Complete prescriber and site of insertion information

Prescriber must authorize and confirm the information is correct by signing and dating



PATIENT ENROLLMENT FORM

Dextenza®
(dexamethasone ophthalmic insert) 0.4 mg
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This form should be completed by a prescriber and/or office staff, signed by a prescriber, and submitted prior to insertion. Please fax form, along with copies of the patient's medical insurance cards, both front and back to: **1-855-518-7564**. For electronic submission, visit **www.MyOcuCare.com**.

PATIENT INFORMATION
Name (First, Middle and Last): _____ Date of Birth: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Email: _____

PATIENT INSURANCE INFORMATION (Please attach copy of medical insurance cards (both sides))
Patient is Uninsured: ☐ Yes ☐ No

PRIMARY INSURANCE **Copy of insurance card attached:** ☐ Yes ☐ No
Insurance Plan Name: _____ Phone Number: _____
Plan Type/Sub Type: _____ Group Number: _____ Policy Number: _____

SECONDARY INSURANCE **Copy of insurance card attached:** ☐ Yes ☐ No
Insurance Plan Name: _____ Phone Number: _____
Plan Type/Sub Type: _____ Group Number: _____ Policy Number: _____

TREATMENT INFORMATION **Product Name: DEXTENZA® (dexamethasone ophthalmic insert) 0.4mg**
Please include specific ICD-10 code(s): _____ Right Eye: _____ Left Eye: _____ Bilateral: _____
Date of Insertion: _____ DEXTENZA Insertion Site: ☐ HOPD ☐ ASC ☐ HCP Office
DEXTENZA Administration (CPT Code): **68841**

PRESCRIBER INFORMATION All fields must be completed. ☐ MD ☐ DO (Osteopath) ☐ OD (Optometrist)
Prescriber Name: _____ Prescriber NPI#: _____
Office Name: _____ Tax ID#: _____ PTAN: _____
Office Address (not PO Box): _____
City: _____ State: ____ Zip Code: _____ Phone: _____ Fax: _____
Primary Contact: _____ Email: _____

SITE OF INSERTION
Facility Name: _____ Facility NPI: _____ Facility Tax ID#: _____
Address (not PO Box): _____ City: _____ State: ____ Zip Code: _____
Site Contact Name: _____ Phone: _____
Fax: _____ Email: _____

PRESCRIBER AUTHORIZATION
☐ I authorize the use or disclosure of the patient's health information contained on this enrollment form to Ocular's OcuCare™ program, Ocular Therapeutix, and the patient's health insurers to determine the patient's insurance benefits for DEXTENZA. I also authorize Ocular's OcuCare program to follow up with said health plan on my behalf to determine status of a prior authorization submitted on behalf of the patient and to assist with any claim denial appeals. I certify that I have obtained my patient's authorization as required by HIPAA to use and disclose patient's personally identifiable health information (including diagnosis, treatment, and insurance information, contained in this form), for the purposes permitted under this "Prescriber Authorization" Section. I agree that the patient's providers, insurers, and other designees may contact me for additional information as needed relating to the patient's DEXTENZA therapy. I certify that I am the physician who has prescribed DEXTENZA to the identified patient; DEXTENZA is medically necessary for this patient; and the information provided on this form is accurate to the best of my knowledge.

Prescriber Signature: _____ Date: _____

Phone: 1-877-286-2207 | **Fax:** 1-855-518-7564 | **www.DEXTENZA.com**

OcuCare™
PATIENT ACCESS AND REIMBURSEMENT SERVICES

Submit the form via www.MyOcuCare.com* or fax 1-855-518-7564

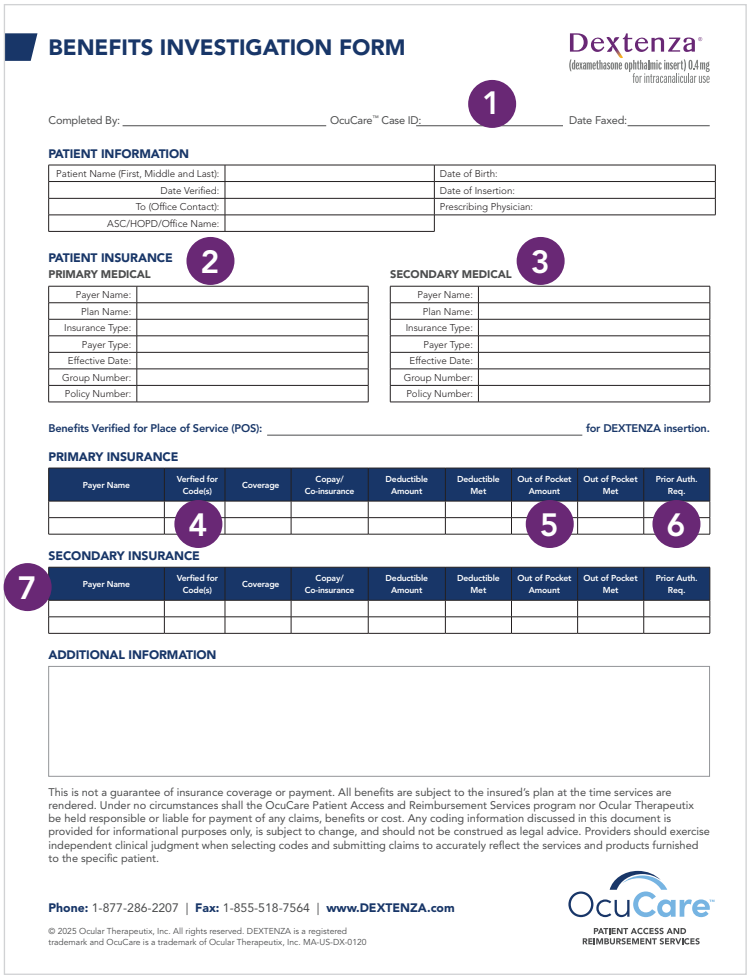
*A secure, online portal and convenient option to enroll and manage patients in OcuCare support programs. Provides instant access to patient case status updates 24 hours a day, 7 days a week. Registration Required.

OcuCare™
PATIENT ACCESS AND REIMBURSEMENT SERVICES

Benefits Investigation Form

The **OcuCare Benefits Investigation Form** provides the information you need returned via fax or available in the MyOcuCare.com portal (if registered). Comprehensive and convenient, receive results within 48 hours or less.

1. **OcuCare Case ID:** Refer to this number when speaking to your OcuCare Case Manager
2. **Primary Medical:** OcuCare will verify patient's primary insurance coverage
3. **Secondary Medical:** OcuCare will verify patient's secondary insurance coverage
4. **DEXTENZA Billing Code:** Provides suggested billing guidelines for the DEXTENZA product HCPCS J-code and CPT Code (physician/facility fee)
5. **DEXTENZA Cost Share:** Indicates patient's financial responsibility for the product
6. **Prior Authorization Required:** Indicates if the patient's plan requires a prior authorization for DEXTENZA
7. **Secondary Insurance:** Patient's payer specific coverage information and suggested codes



BENEFITS INVESTIGATION FORM

Dextenza® (dexamethasone ophthalmic insert) 0.4 mg for intracanalicular use

Completed By: _____ OcuCare™ Case ID: 1 _____ Date Faxed: _____

PATIENT INFORMATION

Patient Name (First, Middle and Last):		Date of Birth:
Date Verified:		Date of Insertion:
To (Office Contact):		Prescribing Physician:
ASC/HOPD/Office Name:		

PATIENT INSURANCE 2

PRIMARY MEDICAL

Payer Name:	
Plan Name:	
Insurance Type:	
Payer Type:	
Effective Date:	
Group Number:	
Policy Number:	

SECONDARY MEDICAL 3

Payer Name:	
Plan Name:	
Insurance Type:	
Payer Type:	
Effective Date:	
Group Number:	
Policy Number:	

Benefits Verified for Place of Service (POS): _____ for DEXTENZA insertion.

PRIMARY INSURANCE

Payer Name	Verified for Code(s)	Coverage	Copay/ Co-insurance	Deductible Amount	Deductible Met	Out of Pocket Amount	Out of Pocket Met	Prior Auth. Req.
	4					5		6

SECONDARY INSURANCE 7

Payer Name	Verified for Code(s)	Coverage	Copay/ Co-insurance	Deductible Amount	Deductible Met	Out of Pocket Amount	Out of Pocket Met	Prior Auth. Req.

ADDITIONAL INFORMATION

This is not a guarantee of insurance coverage or payment. All benefits are subject to the insured's plan at the time services are rendered. Under no circumstances shall the OcuCare Patient Access and Reimbursement Services program nor Ocular Therapeutix be held responsible or liable for payment of any claims, benefits or cost. Any coding information discussed in this document is provided for informational purposes only, is subject to change, and should not be construed as legal advice. Providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to the specific patient.

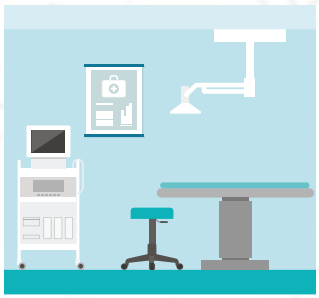
Phone: 1-877-286-2207 | **Fax:** 1-855-518-7564 | **www.DEXTENZA.com**

OcuCare™ PATIENT ACCESS AND REIMBURSEMENT SERVICES

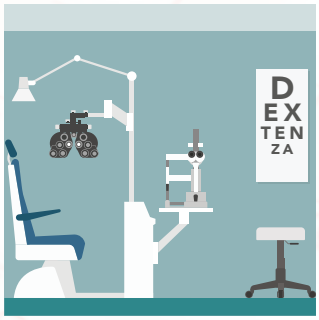
NOTE: The Benefits Investigation Form is not a guarantee of insurance coverage or payment. All benefits are subject to the insured's plan at the time services are rendered. Under no circumstances shall the OcuCare Patient Access and Reimbursement Services program nor Ocular Therapeutix be held responsible or liable for payment of any claims, benefits or cost. Any coding information discussed in this document is provided for informational purposes only, is subject to change, and should not be construed as legal advice. Providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to the specific patient.

OcuCare™ PATIENT ACCESS AND REIMBURSEMENT SERVICES

Sample CMS Forms for DEXTENZA



IN THE OPERATING ROOM ASC/HOPD



IN THE OFFICE

Professional CMS-1500 - Post-Surgical DEXTENZA Insertion in the ASC and in the HOPD

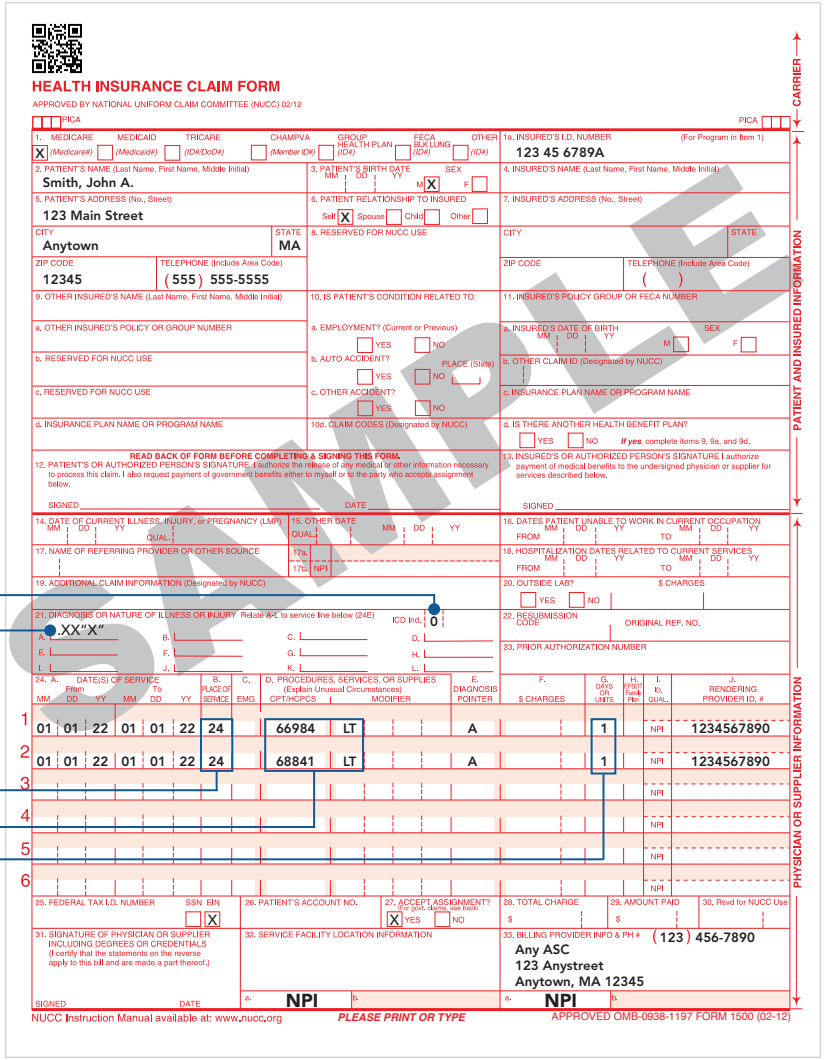
Box 21
Enter the appropriate ICD*-10 code(s).

Box 21
Enter "0" for ICD-10-CM.

Box 24B
Enter operating room place of service, e.g., "24" indicates ASC, "22" indicates HOPD.

Box 24D
Enter the CPT† code for the surgical procedure (e.g., 66984), the CPT code for DEXTENZA insertion (68841) and the relevant modifiers. ****Please refer to the possible applicable modifiers.**

Box 24G
Enter a unit of 1 for the procedure codes (66984 and 68841).



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE X (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123 45 6789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A.

3. PATIENT'S BIRTH DATE MM DD YY | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown | STATE: MA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE MM DD YY | QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) | ICD Ind. 0

A. .XX"X" B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	22	01	01	22	24		66984	LT	A		1		NPI	1234567890
2	01	01	22	01	01	22	24		68841	LT	A		1		NPI	1234567890
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER | SSN EIN X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI | b.

33. BILLING PROVIDER INFO & PH # (123) 456-7890

Any ASC
123 Anystreet
Anytown, MA 12345

a. NPI | b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

*International Classifications of Diseases (ICD).

†CPT® is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®), an alphanumeric coding system maintained by the American Medical Association to identify medical services and procedures provided by physicians and other healthcare professionals.

HCPCS = Healthcare Common Procedure Coding System.

Note: The information presented is based on the paper claim format; please adapt this information to electronic equivalent fields in your software systems. The coding information discussed in this document and sample form is provided for informational purposes only, is subject to change, and should not be construed as legal advice. The codes listed below may not apply to all patients or to all health insurance plans; providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to a specific patient. Providers are responsible for determining the appropriate coding and submission of accurate claims.

Facility CMS-1450 - DEXTENZA Insertion in the HOPD

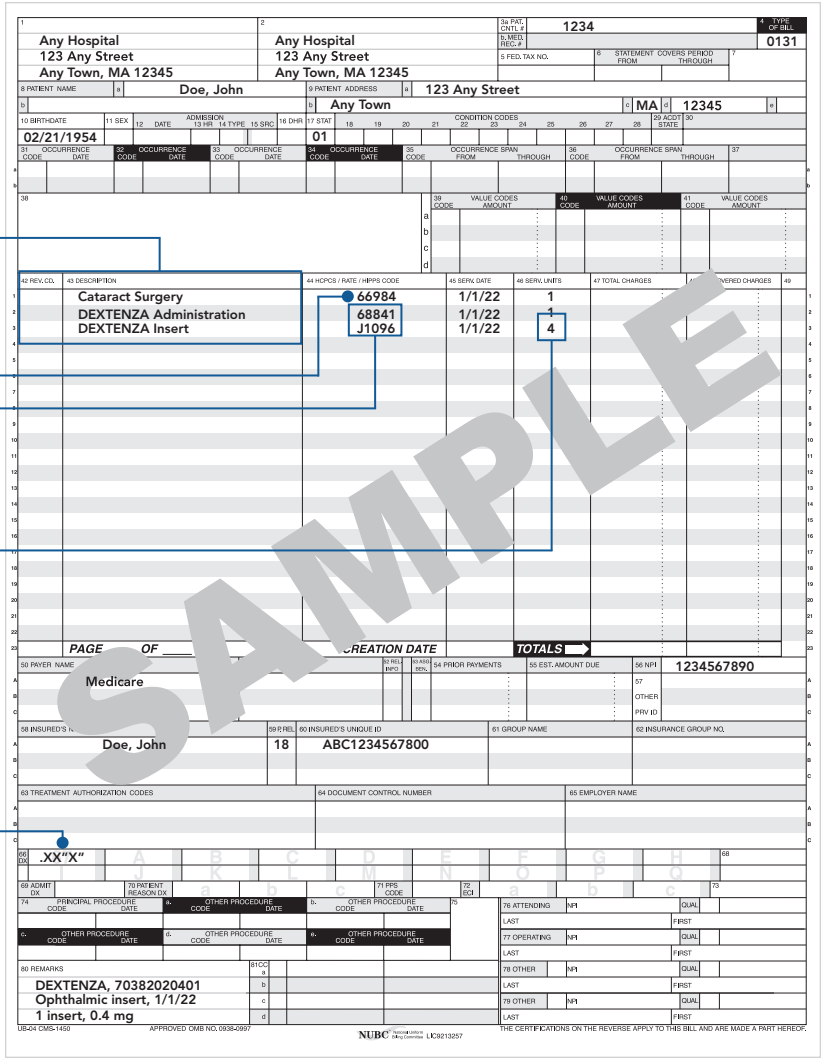
Box 42, 43
Enter revenue code and revenue code description for the type of ophthalmic surgery (e.g., cataract, as shown here) and DEXTENZA.

Box 44
Enter the procedure code to designate cataract surgery.

Box 44
Enter the CPT* code for the surgical procedure (e.g., 66984). Enter the HCPCS code to represent DEXTENZA J-code (J1096) and the CPT code (68841) for DEXTENZA insertion.

Box 46
Enter a unit of 1 for the procedure codes (66984 and 68841). Enter a unit of 4 for the DEXTENZA HCPCS code (J1096). The HCPCS descriptor for DEXTENZA is 0.1mg.

Box 67
Enter the appropriate ICD†-10 code(s).



*CPT® is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®), an alphanumeric coding system maintained by the American Medical Association to identify medical services and procedures provided by physicians and other healthcare professionals.

† International Classifications of Diseases (ICD).

HCPCS = Healthcare Common Procedure Coding System.

Note: The information presented is based on the paper claim format; please adapt this information to electronic equivalent fields in your software systems. The coding information discussed in this document and sample form is provided for informational purposes only, is subject to change, and should not be construed as legal advice. The codes listed below may not apply to all patients or to all health insurance plans; providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to a specific patient. Providers are responsible for determining the appropriate coding and submission of accurate claims.

Click here to return to Table of Contents

Facility CMS-1500 - Post-Surgical DEXTENZA Insertion in the ASC and in the HOPD

Box 21
Enter the appropriate ICD*-10 code(s).

Box 21
Enter "0" for ICD-10-CM.

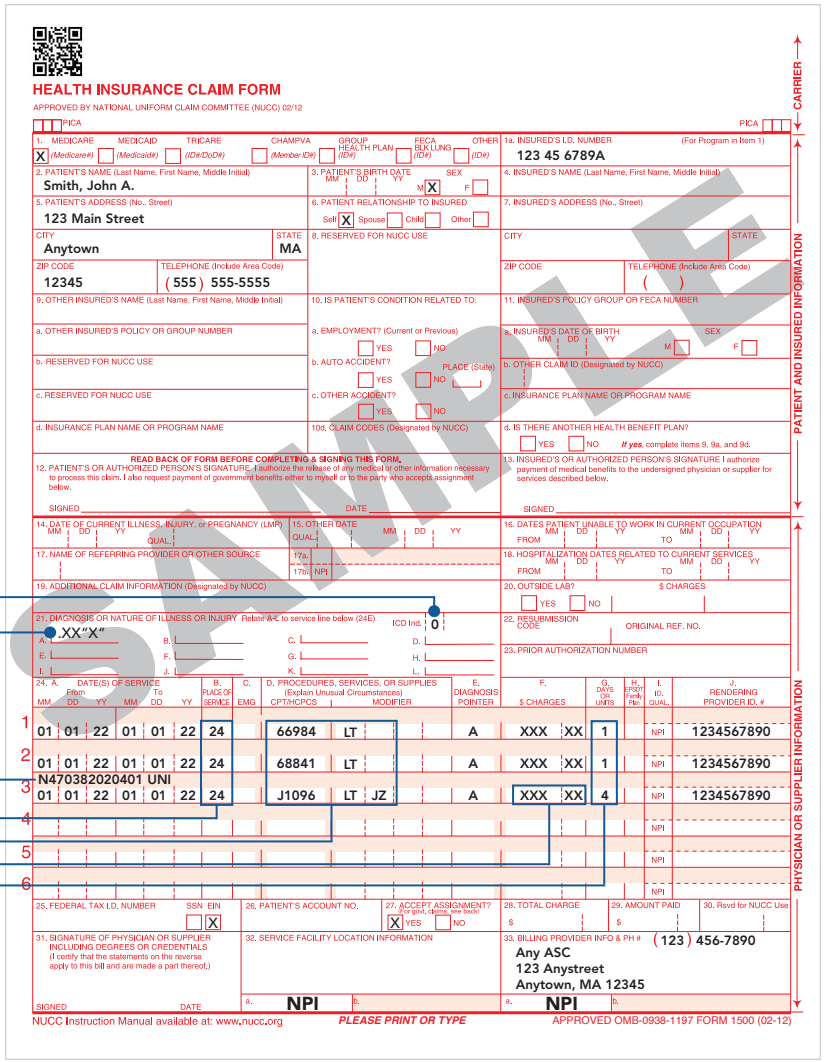
Box 24A
Enter N4 qualifier and 11-digit NDC code: N470382020401 UN1.†

Box 24B
Enter "24" for ASC.

Box 24D
Enter the CPT‡ code for the surgical procedure (e.g., 66984). Enter the HCPCS code to represent DEXTENZA (J1096) and the CPT code (68841) for DEXTENZA insertion.
****Please refer to the possible applicable modifiers.**

Box 24F
Enter price of DEXTENZA from price schedule.

Box 24G
Enter a unit of 1 for the procedure codes (66984 and 68841). Enter a unit of 4 for the DEXTENZA HCPCS code (J1096). The HCPCS descriptor for DEXTENZA is 0.1mg.


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE X (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123 45 6789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A.

3. PATIENT'S BIRTH DATE MM DD YY | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown | STATE: MA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. .XX"X" B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 22	01 01 22	24		66984	LT	A	XXX	XX 1		NPI	1234567890
2 01 01 22	01 01 22	24		68841	LT	A	XXX	XX 1		NPI	1234567890
3 N470382020401 UNI 01 01 22	01 01 22	24		J1096	LT JZ	A	XXX	XX 4		NPI	1234567890
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (123) 456-7890
Any ASC
123 Anystreet
Anytown, MA 12345

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

*International Classifications of Diseases (ICD).

†NDC is to be preceded with the qualifier N4 and followed immediately by the 11-digit NDC in positions 01 through 13. Quantity of NDC is to be preceded by the appropriate qualifier (UN = units) in positions 17 through 24.

‡CPT® is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®), an alphanumeric coding system maintained by the American Medical Association to identify medical services and procedures provided by physicians and other healthcare professionals.

HCPCS = Healthcare Common Procedure Coding System.

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Professional CMS-1500 - Post-Surgical DEXTENZA Insertion in the Office

Box 21
Enter the appropriate ICD*-10 code(s).

Box 21
Enter "0" for ICD-10-CM.

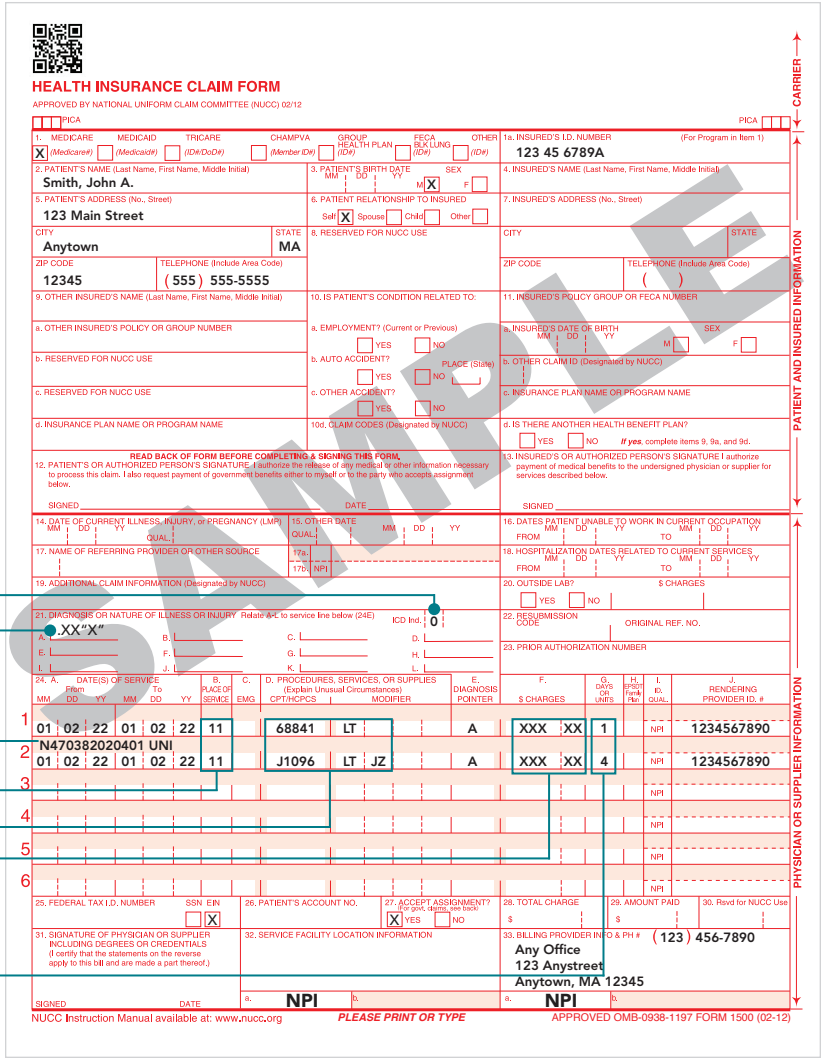
Box 24A
Enter N4 qualifier and 11-digit NDC code: N470382020401 UN1.†

Box 24B
"11" indicates Office.

Box 24D
Enter the CPT‡ code for DEXTENZA insertion (68841), HCPCS code to represent DEXTENZA (J1096) and the relevant modifiers to indicate location and date of insertion.
****Please refer to the possible applicable modifiers.**

Box 24F
Enter price of DEXTENZA from price schedule.

Box 24G
Enter a unit of 1 for each procedure code (68841) and 4 units for the J-code (J1096).



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE X | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123 45 6789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A.

3. PATIENT'S BIRTH DATE | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown | STATE: MA

8. RESERVED FOR NUCC USE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (555) 555-5555

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH | SEX

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) | QUAL.

15. OTHER DATE | QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION | FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | FROM | TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) | ICD Ind. 0

A. .XX"X" B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 02 22	01 02 22	11		68841	LT	A	XXX XX	1		NPI	1234567890
2	N470382020401 UNI											
	01 02 22	01 02 22	11		J1096	LT JZ	A	XXX XX	4		NPI	1234567890
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER | SSN EIN X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI | b.

33. BILLING PROVIDER INFO & PH # (123) 456-7890
Any Office
123 Anystreet
Anytown, MA 12345

a. NPI | b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

*International Classifications of Diseases (ICD).

†NDC is to be preceded with the qualifier N4 and followed immediately by the 11-digit NDC in positions 01 through 13. Quantity of NDC is to be preceded by the appropriate qualifier (UN = units) in positions 17 through 24.

‡CPT® is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®), an alphanumeric coding system maintained by the American Medical Association to identify medical services and procedures provided by physicians and other healthcare professionals.

HCPCS = Healthcare Common Procedure Coding System.

Note: The information presented is based on the paper claim format; please adapt this information to electronic equivalent fields in your software systems. The coding information discussed in this document and sample form is provided for informational purposes only, is subject to change, and should not be construed as legal advice. The codes listed below may not apply to all patients or to all health insurance plans; providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to a specific patient. Providers are responsible for determining the appropriate coding and submission of accurate claims.

Professional CMS-1500 - DEXTENZA Insertion for Non-Surgical Purposes in the Office

Box 21
Enter the appropriate ICD*-10 code(s).

Box 21
Enter "0" for ICD-10-CM.

Box 24A
Enter N4 qualifier and 11-digit NDC code: N470382020401 UN1.†

Box 24B
"11" indicates Office.

Box 24D
Enter the CPT‡ code for DEXTENZA insertion (68841), HCPCS code to represent DEXTENZA (J1096) and the relevant modifiers to indicate location and date of insertion. ****Please refer to the possible applicable modifiers.**

Box 24F
Enter price of DEXTENZA from price schedule.

Box 24G
Enter a unit of "1" for each 68841 procedure e.g., for bilateral procedures enter "2" units and enter a unit of "4" for each DEXTENZA inserted, e.g., for bilateral insertions enter "8" units.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE X (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123 45 6789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A.

3. PATIENT'S BIRTH DATE MM DD YY | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown | STATE: MA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. .XX"X" B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 22	01 01 22	11		68841	50	A	XXX XX	2		NPI 1234567890
2	N470382020401 UNI 01 01 22	01 01 22	11		J1096	JZ	A	XXX XX	8		NPI 1234567890
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER | SSN | EIN X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI | b.

33. BILLING PROVIDER INFO & PH # (123) 456-7890
Any Office
123 Anystreet
Anytown, MA 12345

a. NPI | b.

NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | APPROVED OMB-0938-1197 FORM 1500 (02-12)

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IMPORTANT SAFETY INFORMATION

INDICATIONS

DEXTENZA is a corticosteroid indicated for:

- The treatment of ocular inflammation and pain following ophthalmic surgery in adults and pediatric patients
- The treatment of ocular itching associated with allergic conjunctivitis in adults and pediatric patients aged 2 years and older
    - o Limitations of Use
      The use of DEXTENZA is not recommended for the treatment of ocular itching associated with allergic conjunctivitis in pediatric patients who require sedation for the insertion procedure

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

DEXTENZA is contraindicated in patients with active corneal, conjunctival or canalicular infections, including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella; mycobacterial infections; fungal diseases of the eye, and dacryocystitis.

WARNINGS AND PRECAUTIONS

Intraocular Pressure Increase - Prolonged use of corticosteroids may result in glaucoma with damage to the optic nerve, defects in visual acuity and fields of vision. Steroids should be used with caution in the presence of glaucoma. Intraocular pressure should be monitored during treatment.

Bacterial Infections - Corticosteroids may suppress the host response and thus increase the hazard for secondary ocular infections. In acute purulent conditions, steroids may mask infection and enhance existing infection.

Viral Infections - Use of ocular steroids may prolong the course and may exacerbate the severity of many viral infections of the eye (including herpes simplex).

Fungal Infections - Fungus invasion must be considered in any persistent corneal ulceration where a steroid has been used or is in use. Fungal culture should be taken when appropriate.

Delayed Healing - Use of steroids after cataract surgery may delay healing and increase the incidence of bleb formation.

Other Potential Corticosteroid Complications -
The initial prescription and renewal of the medication order of DEXTENZA should be made by a physician only after examination of the patient with the aid of magnification, such as slit lamp biomicroscopy, and, where appropriate, fluorescein staining. If signs and symptoms fail to improve after 2 days, the patient should be re-evaluated.

ADVERSE REACTIONS

Ocular Inflammation and Pain Following Ophthalmic Surgery
The most common ocular adverse reactions that occurred in patients treated with DEXTENZA were: anterior chamber inflammation including iritis and iridocyclitis (10%), intraocular pressure increased (6%), visual acuity reduced (2%), cystoid macular edema (1%), corneal edema (1%), eye pain (1%), and conjunctival hyperemia (1%). The most common non-ocular adverse reaction was headache (1%).

Itching Associated with Allergic Conjunctivitis
The most common ocular adverse reactions that occurred in patients treated with DEXTENZA were: intraocular pressure increased (3%), lacrimation increased (1%), eye discharge (1%), and visual acuity reduced (1%). The most common non-ocular adverse reaction was headache (1%).

Click here for full Prescribing Information.

Click here to learn more at www.dextenza.com.

LEARN MORE AT
DEXTENZA.COM

OcuCare™

PATIENT ACCESS AND REIMBURSEMENT SERVICES

ORDERING AND REIMBURSEMENT

OCULAR THERAPEUTIX™