PATIENT ASSISTANCE PROGRAM APPLICATION FORM

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

In consideration for this program, completed application MUST be received at least 5 business days prior to DEXTENZA insertion date and patient must be enrolled in the DEXTENZA360 Program to qualify. Enrollment available via fax or electronically at **www.DEXTENZA360.com**.

Complete
Review and complete entire form

Sign
Patient and physician signatures required

Fax to DEXTENZA360 at 1-855-518-7564

Patient Name (First, Middle and Last):

Date of Birth (MM/DD/YY):

Patient Phone Number:

Date of Insertion (MM/DD/YY):

Prescriber Name (Print):

Prescriber Address:

DEXTENZA Patient Assistance Program (PAP) for Uninsured/Underinsured

Patients without health insurance may be eligible to receive DEXTENZA free of charge, including patients who do not have drug coverage under Medicare, Medicaid, or a public or private insurance plan, or who do not have drug coverage specific to DEXTENZA.

Social Security Number:

Annual Adjusted Gross Household Income: $

Number of Family Members Living in Household:

Please check all that apply: ☐ Resident of the United States ☐ No Prescription Coverage

Please indicate the amount spent on the following expenses for the previous year. The Program will take these expenses into consideration when reviewing the Application.

Medical Insurance Premiums: $

Uncovered Medical Expenses: $

Credit Card Debt: $

Alimony/Child Support: $

College Tuition*: $

*Must be for a member of immediate family and include only those payments which were made to the educational institution.

Patient Authorization to Use/Disclose Health Information: DEXTENZA Support Services

By signing below, I authorize **Ocular Therapeutix (Ocular)** and its representatives, agents, and contractors, including the **DEXTENZA360** Program operated by Eversana on behalf of **Ocular** (collectively, the Entities) to use and share among themselves my personal health information relevant to my treatment with **Ocular** products (my PHI) for purposes of (1) providing the services offered by **DEXTENZA360** (the program); (2) undertaking financial support services, including benefits verification, potential out-of-pocket costs, and eligibility for financial assistance; (3) to see if I qualify for patient assistance; (4) facilitating the dispensing of medication, supplies, or services by **Ocular**; (5) providing product support and services; (6) undertaking other online support, education, and assistance services; I understand that once my PHI is shared with certain Entities as described above, it may not remain protected by federal privacy law and could be disclosed to others.

I understand that I may refuse to sign this authorization and that if I do refuse, that it would not affect my rights to treatment or health benefits, but it would prevent me from enrolling in the **DEXTENZA360** program. I also understand that I may cancel this authorization at any time by writing to **DEXTENZA360**, **Ocular Therapeutix, Inc.**, 24 Crosby Drive, Bedford, MA 01730 and requesting such cancellation, but that any such cancellation will not affect the sharing and use of my PHI by the Entities before they actually receive notice of my cancellation. If I do not cancel this authorization earlier, it will remain valid for **10 years** from the date of my signature below. I understand that I have a right to receive a copy of this authorization when it is signed. If my application is approved and I receive DEXTENZA free of charge, I agree to inform my health plan (if applicable).

Patient or Representative Name (Print):

Patient or Representative Signature:

Date (MM/DD/YY):

Relationship to Patient (if signed by a representative):

Prescription (Rx) and Physician Attestation

Product Name: DEXTENZA® (dexamethasone ophthalmic insert) 0.4 mg

Directions for Use:

Quantity:

DAW: ☐ Substitution Allowed ☐ Brand Name Only

Prescriber Name (Print):

Prescriber Signature:

Date (MM/DD/YY):

National Provider Identifier Standard (NPI):

Prescriber Phone Number:

Physician Attestation: By signing this form, I certify that the person named on this form is my patient, the information provided is complete and accurate, and the DEXTENZA received in response to this application is only for the approved indicated use of DEXTENZA for the patient named on this form. In the event the product is shipped and patient's surgery/procedure does not take place, I understand myself or a facility representative is responsible for returning/destroying the product according to state and federal regulations. If the surgery/procedure is rescheduled for a later date, I attest to store and reserve the product for the patient according to the proper storage and handling procedures.

I acknowledge that DEXTENZA will not be offered for sale, and no claim for reimbursement of the DEXTENZA product will be submitted to Medicare, Medicaid, or any third-party payer. I understand that Ocular has the right to contact my patient to arrange shipment of DEXTENZA, and to modify or discontinue the program at any time. I confirm that by signing this form, I am licensed to practice at the requested shipment location.

If you are a prescriber in Alabama, Indiana, Kansas, Mississippi, New Jersey, South Carolina, and Washington and are requesting DEXTENZA, you must attach a prescription on your state official prescription form with this application.

Ocular Therapeutix reserves the right to modify or discontinue the DEXTENZA360 Patient Assistance Program in part or in its entirety, at any time.

Phone: 877-286-2207 | **Fax:** 1-855-518-7564 | **www.DEXTENZA360.com**

Dextenza360™
Patient Access and Reimbursement Services