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

Dextenza 360™
Patient Access and Reimbursement Services

Phone: **1-800-339-8369 Option 4 (800-DEXTENZA)**
Fax: **1-855-518-7564**
Mon - Fri 8am - 8pm (ET)
www.DEXTENZA360.com

DEXTENZA® Patient Assistance Program Application

COMPLETE - Review and complete entire form

SIGN - Patient and physician signatures required

FAX to DEXTENZA360 at **1-855-518-7564** or **give completed form to your MD's office to fax for you**

Patient Name (Last, First):

Date of Birth:

Physician:

Date of Surgery/DEXTENZA Insertion:

Site of Surgery:

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. 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; (7) enabling **Ocular** and its agents to provide me with information, including promotional and product materials, regarding offers, services, and programs, educational training and ongoing support on the use of **Ocular** products that may be of interest to me, and to contact me by mail, e-mail, or telephone to discuss **Ocular** products and obtain feedback (for market research purposes). 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 further authorize pharmacies to use my PHI to communicate with me about the medicinal product that has been prescribed for me and that they may receive a fee for such communication.

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.,** 15 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:

Relationship to Patient (if signed by a representative):

Prescription (Rx) and Physician Attestation

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

Directions for Use:

Quantity:

DAW: ◯ Substitution Allowed ◯ Brand Name Only

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 Therapeutix 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, New York, South Carolina, or Washington and are requesting DEXTENZA, you must attach a prescription on your state official prescription form with this application.

Prescriber Name (Print):

Prescriber Signature:

Date:

National Provider Identifier Standard (NPI):

Ocular Therapeutix reserves the right to modify or discontinue the DEXTENZA360 Patient Assistance Program in part or in its entirety, at any time. Free product is contingent upon Program eligibility requirements.

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