DEXTENZA® COMMERCIAL COVERAGE PROGRAM
Reimbursement Certification Form

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

If an insurer payment does not fully cover the cost of DEXTENZA, and your patient has qualified for the DEXTENZA360™ Commercial Coverage Program, Ocular Therapeutix will pay the provider/facility, on behalf of the patient, the remaining patient responsibility not covered by the plan.*

To receive payment in a timely manner, 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.
- Completed and signed Reimbursement Certification Form. Form may be signed by either the physician OR the office/facility administrator.
- Fax the signed Certification Form, along with the EOB to **DEXTENZA360** at **1-855-518-7564.**

Once the form and supporting documentation is received, DEXTENZA360 will process payment. Payment is provided via check or electronically (ACH), depending on preference.

Patient Information

First Name: | Last Name: | DOB: (MM/DD/YY) | Date of Insertion: (MM/DD/YY) | Physician Name:

Facility/Office Information

Please provide the name and address of the location responsible for billing the patient for DEXTENZA. (Typically, the DEXTENZA purchasing entity.)

Facility/Office Name:

Facility/Office Address:

NOTE: Payment will be sent/processed to this location on the patient's behalf

Office Certification

My signature below certifies that the patient named above is my patient or a patient of this surgery center and that the information provided is, to the best of my knowledge, complete and accurate. I consent to Ocular Therapeutix representatives and agents contacting me and this facility to request additional information. I, and this facility/office agree that Ocular Therapeutix may change or terminate any of the DEXTENZA360 program services at any time without notice. Once payment is received, I agree to return any co-pay/co-insurance collected from my patient for the DEXTENZA product.

Signatory Name:

Signatory Title:

Signature:

Date: (MM/DD/YY)

If all information is provided and there is no missing information, you should receive payment on behalf of your patient for any outstanding claim balance for DEXTENZA. If there is any missing information, the payment will not be processed until the information is received.

** Up to the provider/facility acquisition cost (not to exceed $555). Program applies to the patient's out-of-pocket cost for drug only. Payment is independent of any remaining deductible amount.*

Please fax completed and signed form to 1-855-518-7564. For any questions, please call 1-800-339-8369 Option 4.

DISCLAIMER:
DEXTENZA360 program services are subject to change without notice. The DEXTENZA Commercial Coverage Program patient benefit is not available for patients with any government insurance. 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.

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Dextenza360™
Patient Access and Reimbursement Services