Quick and easy support with DEXTENZA360™

The DEXTENZA Enrollment Form allows you to request a wide range of resources to support you and your DEXTENZA patients.

The support you need starts with this simple form.

Select the support requested **1:1**

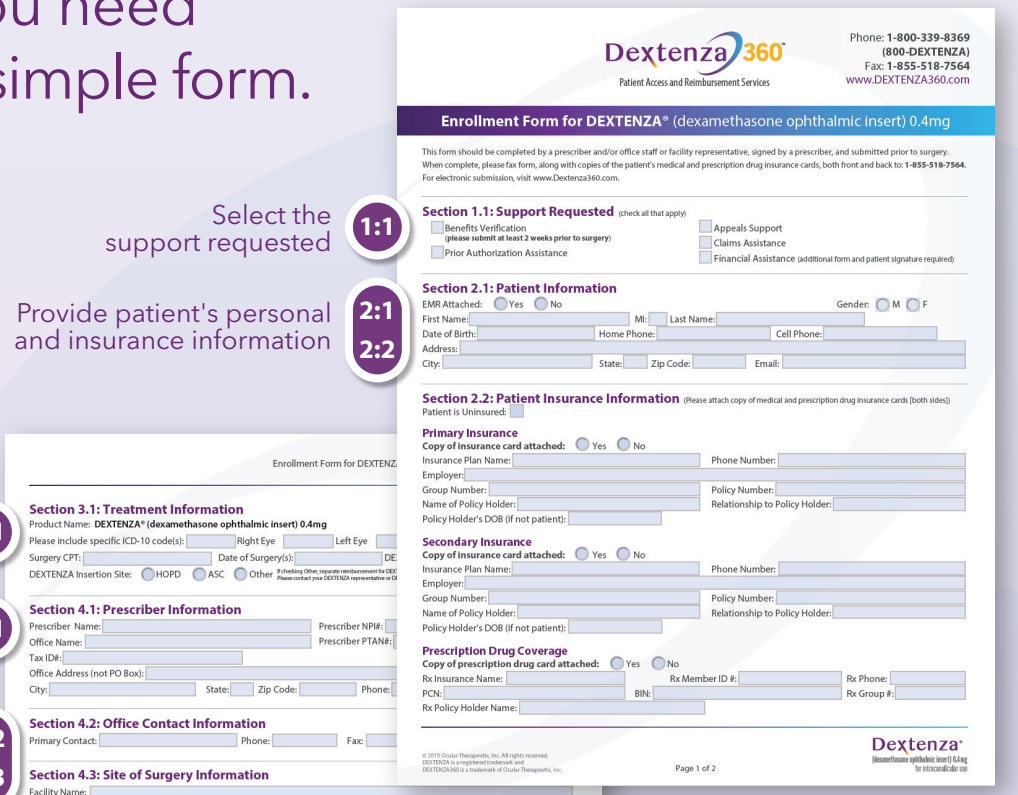
Provide patient's personal and insurance information **2:1** **2:2**

Provide treatment information and be sure to include the date of surgery **3:1**

Provide prescriber information **4:1**

Complete office and surgical facility information **4:2** **4:3**

Prescriber must authorize and confirm the information is correct by signing and dating **4:4**



Dextenza 360
Patient Access and Reimbursement Services

Phone: 1-800-339-8369
(800-DEXTENZA)
Fax: 1-855-518-7564
www.DEXTENZA360.com

Enrollment Form for DEXTENZA® (dexamethasone ophthalmic insert) 0.4mg

This form should be completed by a prescriber and/or office staff or facility representative, signed by a prescriber, and submitted prior to surgery. When complete, please fax form, along with copies of the patient's medical and prescription drug insurance cards, both front and back to: 1-855-518-7564. For electronic submission, visit www.Dextenza360.com.

Section 1.1: Support Requested (check all that apply)

- Benefits Verification (please submit at least 2 weeks prior to surgery)
- Prior Authorization Assistance
- Appeals Support
- Claims Assistance
- Financial Assistance (additional form and patient signature required)

Section 2.1: Patient Information

EMR Attached: Yes No Gender: M F
First Name: MI: Last Name:
Date of Birth: Home Phone: Cell Phone:
Address:
City: State: Zip Code: Email:

Section 2.2: Patient Insurance Information (Please attach copy of medical and prescription drug insurance cards (both sides))

Patient is Uninsured:

Primary Insurance
Copy of insurance card attached: Yes No
Insurance Plan Name: Phone Number:
Employer:
Group Number: Policy Number:
Name of Policy Holder: Relationship to Policy Holder:
Policy Holder's DOB (if not patient):

Secondary Insurance
Copy of insurance card attached: Yes No
Insurance Plan Name: Phone Number:
Employer:
Group Number: Policy Number:
Name of Policy Holder: Relationship to Policy Holder:
Policy Holder's DOB (if not patient):

Prescription Drug Coverage
Copy of prescription drug card attached: Yes No
Rx Insurance Name: Rx Member ID #: Rx Phone:
PCN: BIN: Rx Group #:
Rx Policy Holder Name:

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

Enrollment Form for DEXTENZ

Section 3.1: Treatment Information

Product Name: **DEXTENZA® (dexamethasone ophthalmic insert) 0.4mg**
Please include specific ICD-10 code(s): Right Eye Left Eye
Surgery CPT: Date of Surgery(s):
DEXTENZA Insertion Site: HOPD ASC Other If checking Other, separate reimbursement for DEX Please contact your DEXTENZA representative or DI

Section 4.1: Prescriber Information

Prescriber Name: Prescriber NPI#:
Office Name: Prescriber PTAN#:
Tax ID#:
Office Address (not PO Box):
City: State: Zip Code: Phone:

Section 4.2: Office Contact Information

Primary Contact: Phone: Fax:

Section 4.3: Site of Surgery Information

Facility Name:
Site Contact Name: Direct Line: Email: Fax:
Facility NPI: Facility PTAN#: Facility Tax ID#:
Address (not PO box):
City: State: Zip Code: Phone: Fax:

Section 4.4: Prescriber Authorization

I authorize the use or disclosure of the patient's health information contained on this enrollment form to Ocular's DEXTENZA360™ program, Ocular's Field Reimbursement Managers, and the patient's health insurers to determine the patient's insurance benefits for DEXTENZA . I also authorize Ocular's DEXTENZA360™ 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:
(Valid only upon signature of licensed prescriber)

Please complete this form in it's entirety.
Submit the signed form via fax to 1-855-518-7564.
For electronic submission, visit www.Dextenza360.com.

MA-US-DX-0007-V1

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To submit the form, fax to 1-855-518-7564 or submit via **DEXTENZA360.com***

* A secure, online portal and convenient option to enroll and manage patients in DEXTENZA360 support programs. Provides instant access to patient case status updates 24 hours a day, 7 days a week. Requires registration and e-signature setup.

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Dextenza 360™
Patient Access and Reimbursement Services

Connect with DEXTENZA360™ for the support you and your patients need

The DEXTENZA Benefits Verification Form provides the information you need via fax or the DEXTENZA360 portal (if registered). Comprehensive and convenient--receive results within 48 hours or less.

- **A** DEXTENZA360 Record ID: Refer to this number when speaking to your DEXTENZA360 Case Manager
- **B** Primary Medical: DEXTENZA360 will contact both payers (if applicable) to verify patient's insurance coverage
- **C** Secondary Medical: DEXTENZA360 will contact both payers (if applicable) to verify patient's insurance coverage
- **D** DEXTENZA Billing Code: Provides suggested billing guidelines for the DEXTENZA product HCPCS; J-code and CPT Code (physician/facility fee)
- **E** DEXTENZA Cost Share: Indicates patient's financial responsibility for the product
- **F** DEXTENZA Reimbursement Amount: Amount the plan will allow/reimburse for DEXTENZA (if available). Some payers may not provide this information during the benefits investigation process.
- **G** Prior Authorization Required: Indicates if the patient's plan requires a prior authorization for DEXTENZA
- **H** Secondary Insurance: Patient's payer specific coverage information and suggested codes.
- **I** Narrative Section: Benefit verification summary.
- **J** Patient Financial Responsibility: For both the DEXTENZA insert and insertion.
- **K** Place of Service: Benefits verified per site of care.
- **L** Patient Assistance Programs: Checked if the patient qualifies for any financial assistance program.

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Benefit Verification Form for DEXTENZA® (dexamethasone ophthalmic insert) 0.4mg

Completed By:
DEXTENZA360 Case ID: Date Faxed:

Patient Name: | To: (office contact person)
DEXTENZA360 Record ID: | Prescribing Physician:
Date Verified: | Prescriber Fax:
Patient Date of Birth: | Surgery Center:
Date of Surgery: | Surgery Center Fax:

Patient Insurance

Primary Medical	Secondary Medical	Primary Pharmacy
Payer Name:	Payer Name:	Payer Name:
Plan Name:	Plan Name:	Plan Name:
Insurance Type:	Insurance Type:	Insurance Type:
Payer Type:	Payer Type:	Payer Type:
Effective Date:	Effective Date:	Effective Date:
Group Number:	Group Number:	Group Number:
Policy Number:	Policy Number:	Policy Number:

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

Primary Insurance

Payer Name	Recommended Code(s)*	Coverage	Patient Responsibility	Reimbursement/ Allowable**	Subject to Deductible	Deductible Amount	Deductible Met	Prior Auth Required	Additional Documentation Required
	D		E	F				G	

Secondary Insurance

Payer Name	Recommended Code(s)*	Coverage	Patient Responsibility	Reimbursement/ Allowable**	Subject to Deductible	Deductible Amount	Deductible Met	Prior Auth Required	Additional Documentation Required

* CMS granted J1096 CPT procedure code 0356T.

** Reimbursement amount will be determined by provider/facility specific contract with the insurance carrier.

Contact DEXTENZA360 if you would like more information on the prior authorization process.

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Benefits Verification Fo

Narrative Section

Benefits verified with:

DEXTENZA patient responsibility . DEXTENZA insertion patient resp

Benefits verified and valid for POS only.

Please ensure DEXTENZA is procured prior to the date of surgery. Surgery

Providers/Facilities can purchase DEXTENZA from:
Besse Medical, 1-800-543-2111
Cardinal Specialty Pharma Distribution ,1-855-855-0708
McKesson Specialty Health, 1-855-477-9800
McKesson Plasma & Biologics for Hospitals, 1-877-625-2566
McKess
Henry S
FFF Ent
Metro M

0356T (Insertion of drug-eluting implant, including punctal dilation and canaliculus, each) is a category III temporary CPT code. The code has be Billing the CPT for DEXTENZA insertion – 0356T – is optional and will no are often considered experimental by CMS, and are not assigned a fee s payers to establish a precedent and future reimbursement of 0356T, se

IMPORTANT: For Commercial and Medical Advantage plans, reimburse specific contract with the insurance carrier. Please verify payer contr

Patient Assistance Programs

This patient has qualified for the DEXTENZA Commercial Coverage instructions will follow.

This patient may be eligible for the DEXTENZA Patient Assistance Pr on DEXTENZA360.com or contact DEXTENZA360 at 1-800-339-8369

This is not a guarantee of insurance coverage. All benefits are subject to the in circumstances shall the DEXTENZA360 Reimbursement Support Program nor any claims, benefits or cost. Any coding information discussed in this docume change, and should not be construed as legal advice. Providers should exercis submitting claims to accurately reflect the services and products furnished to

Contact DEXTENZA360 if you would like more information on the prior authorization process.

MA-US-DX-0008-V3

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Making support convenient for you

CLICK **DEXTENZA360.com** for 24/7 online access to interactive tools designed to help you throughout the access and reimbursement process.

CALL **800-339-8369** (800-DEXTENZA) for your dedicated Case Manager Monday–Friday | 8:00 AM – 8:00 PM ET (fax: 855-518-7564).

CONNECT directly with your Ocular Therapeutix Field Reimbursement Manager or DEXTENZA360 Case Manager.

NOTE: The Benefits Summary Form is not a guarantee of insurance coverage. All benefits are subject to the insured's plan at the time services are rendered. Under no circumstances shall DEXTENZA360 be held responsible or liable for payment of any claims, benefits, or costs.

The sample form is an example and may not depict the actual DEXTENZA360 patient/provider information.

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