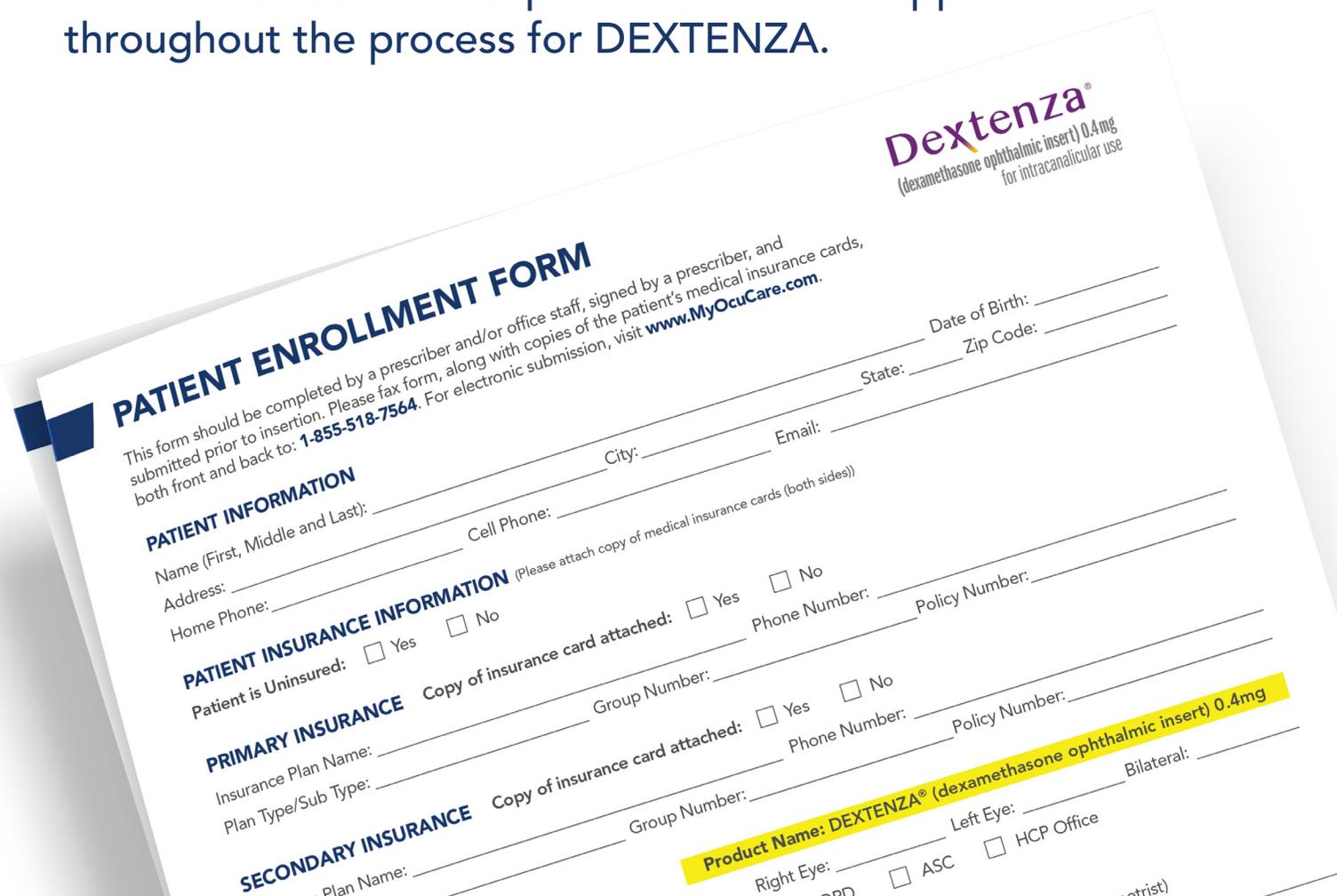




PATIENT ACCESS AND REIMBURSEMENT SERVICES

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

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



Connect to Us

www.DEXTENZA.com

www.MyOcuCare.com



www.twitter.com/OCUTX



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

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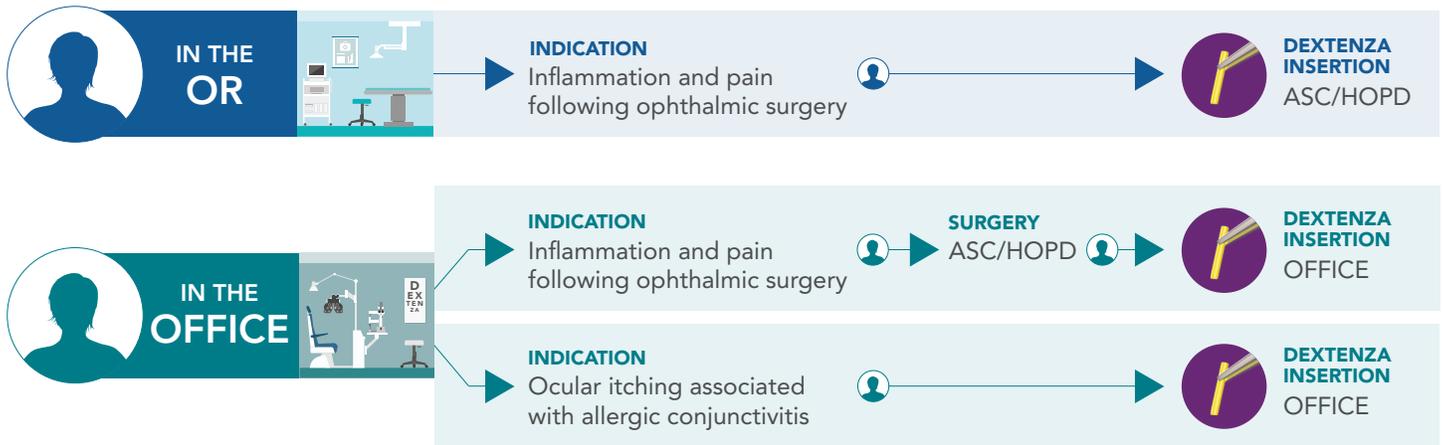
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THE ROLE OF OCUCARE IN PATIENT ACCESS TO DEXTENZA

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

DEXTENZA Patient Journey



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



Your Dedicated DEXTENZA Team

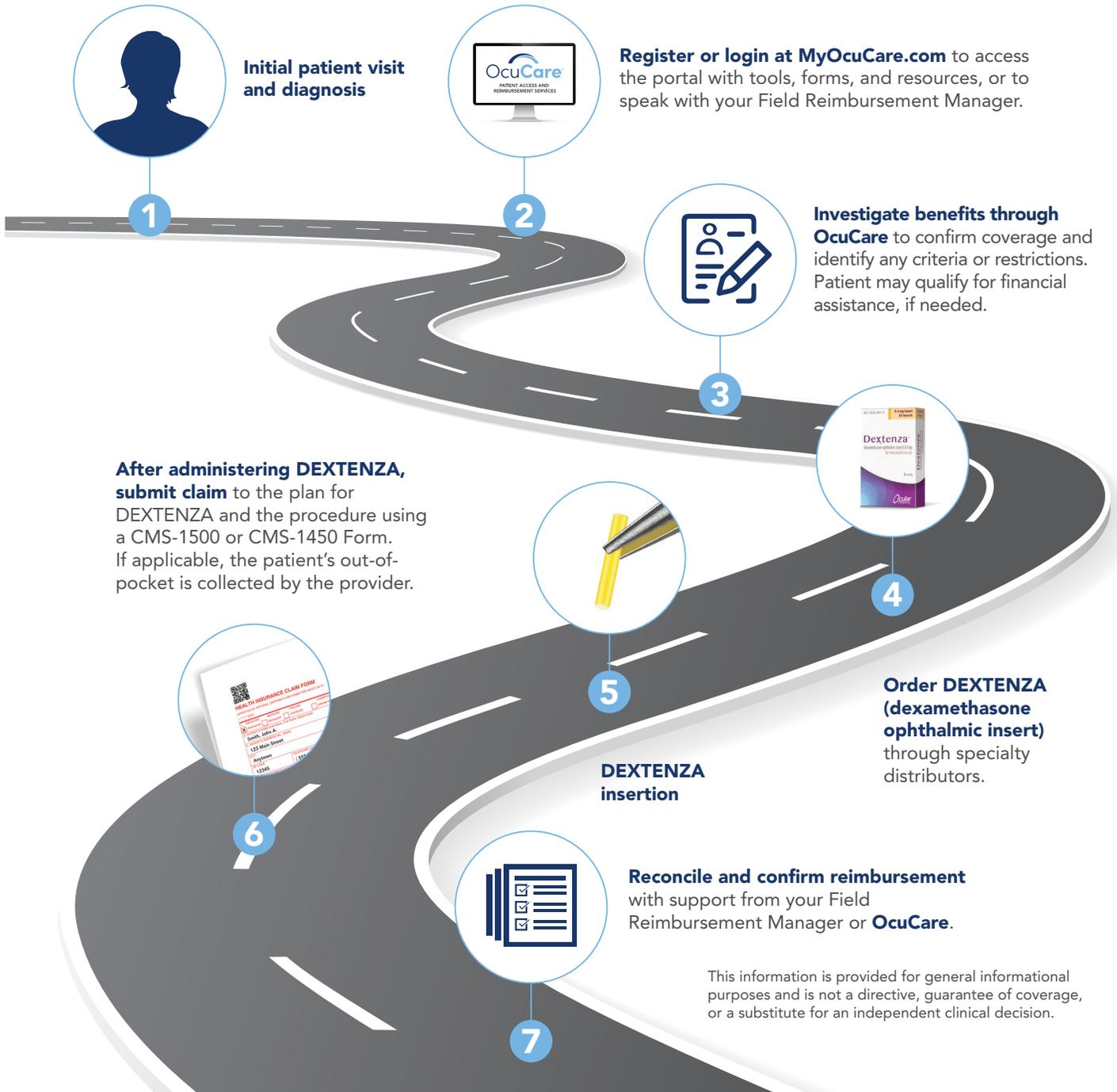


Your dedicated DEXTENZA team consists of a national account director, key account manager, medical director, OcuCare case manager, and field reimbursement manager. Our Medical Affairs team is also available to assist with any questions.



Reimbursement Roadmap

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



Click, Call, or Connect MyOcuCare.com

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
[Distributor Name]	[Distributor Phone]	[Distributor Fax]	[Distributor Website]
[Distributor Name]	[Distributor Phone]	[Distributor Fax]	[Distributor Website]
[Distributor Name]	[Distributor Phone]	[Distributor Fax]	[Distributor Website]
[Distributor Name]	[Distributor Phone]	[Distributor Fax]	[Distributor Website]
[Distributor Name]	[Distributor Phone]	[Distributor Fax]	[Distributor Website]

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 supplied¹

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 handling¹

- 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.; 2021.

BILLING CODES FOR DEXTENZA

Product and Procedure Billing Codes

Product Reimbursement

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

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

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

Procedure Reimbursement

Procedure Code	Description
68841 CPT-code [§]	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed into lacrimal canaliculus, each)

* 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.

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

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

§ 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.

ICD-10 Codes

Clinical diagnosis and coding are at the discretion of the healthcare provider. Information provided below is for reference of possible applicable ICD-10 codes.

This may not be a complete list of codes. Visit <https://www.cms.gov/medicare/icd-10/2024-icd-10-cm> for a complete list of ICD-10 codes.

ICD*-10 Codes Associated with Ophthalmic Surgery

Ophthalmic Surgery	General	Right Eye	Left Eye	Bilateral	Unspecified Eye
Ocular pain	H57.1	H57.11	H57.12	H57.13	H57.10
Cataract extraction status	Z98.4	Z98.41	Z98.42	-	Z98.49
Presence of intraocular lens; presence of pseudophakia	Z96.1	-	-	-	-
Cortical age-related cataract	H25.01	H25.011	H25.012	H25.013	H25.019
Other acute postprocedural pain	G89.18	-	-	-	-

ICD-10 Codes Associated with Allergic Conjunctivitis

Allergic Conjunctivitis	General	Right Eye	Left Eye	Bilateral	Unspecified Eye
Acute atopic conjunctivitis	H10.1	H10.11	H10.12	H10.13	H10.10
Unspecified acute conjunctivitis	H10.3	H10.31	H10.32	H10.33	H10.30
Chronic conjunctivitis	H10.4	H10.401	H10.402	H10.403	H10.409
Chronic giant papillary conjunctivitis	H10.41	H10.411	H10.412	H10.413	H10.419
Vernal conjunctivitis	H10.44				
Other chronic allergic conjunctivitis	H10.45				
Other conjunctivitis	H10.89				
Unspecified conjunctivitis	H10.9				
Conjunctivitis	H10				
Unspecified chronic conjunctivitis	H10.40				

*International Classifications of Diseases (ICD).



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/medhcpcsgeninfo>

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. Visit <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update> for a complete list of modifiers.

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
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



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) 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

 A screenshot of the Patient Assistance Program Application Form, showing various fields for patient information, insurance details, and a section for the pharmacist.

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.

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 attestation 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.

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, Call, or Connect MyOcuCare.com

REPLACEMENT FORM

ELIGIBILITY ATTESTATION FORM Dextenza®
REQUEST FOR REPLACEMENT OF UNUSABLE PRODUCT (dexamethasone ophthalmic insert) 0.4mg
for intracanalicular use

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

- Please complete this form in its entirety and fax to OcuCare at 1-855-518-7564
- The physician/provider must sign the attestation.
- 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 has, in its sole discretion, to deny replacement when misuse is suspected.

PHYSICIAN/PROVIDER INFORMATION:

Physician Name: _____ Date of Incident: _____ Signing Provider Name: _____
 Invoicing Provider Identifier (NPI): _____ Signing Provider Identifier (NPI): _____
 Facility Name: _____ Signing Provider State License #: _____
 Facility Address: _____ Facility State: _____ Zip Code: _____
 Contact Name: _____ Facility City: _____
 Contact Phone: _____ Contact Email: _____
 Contact Fax: _____

ATTESTATION STATEMENT:

I, an authorized person with quantity listed in box: _____ (Signing Provider Name), hereby attest that DEXTENZA is not usable due to incident below with quantity listed in box:

Hydration before patient insertion (swelling) Delivery Address: _____
 Manufacturing or shipping Postage address of all replacement product _____
 Patch being introduced or damaged (This address will be placed _____)
 Temperature not being maintained at 2-8°C (36-46°F) _____ would be placed _____
 Missing product in the pouch
 Other (Please provide explanation: _____)
 Total quantity listed _____

DEXTENZA PRODUCT INFORMATION:

Lot # _____ Lot # _____ Lot # _____
 Lot # _____ Lot # _____ Lot # _____

I certify the product will be destroyed in accordance with federal and state regulations. Product return not required.

I certify the product will be destroyed in accordance with federal and state regulations. Product return not required.

To sign this form, ensure that this information is true, accurate and complete to the best of my knowledge.

Incident being reported by: _____

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

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OcuCare™
PATIENT ACCESS AND REIMBURSEMENT SERVICES



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](https://myocucare.com)

MyOcuCare.com Portal

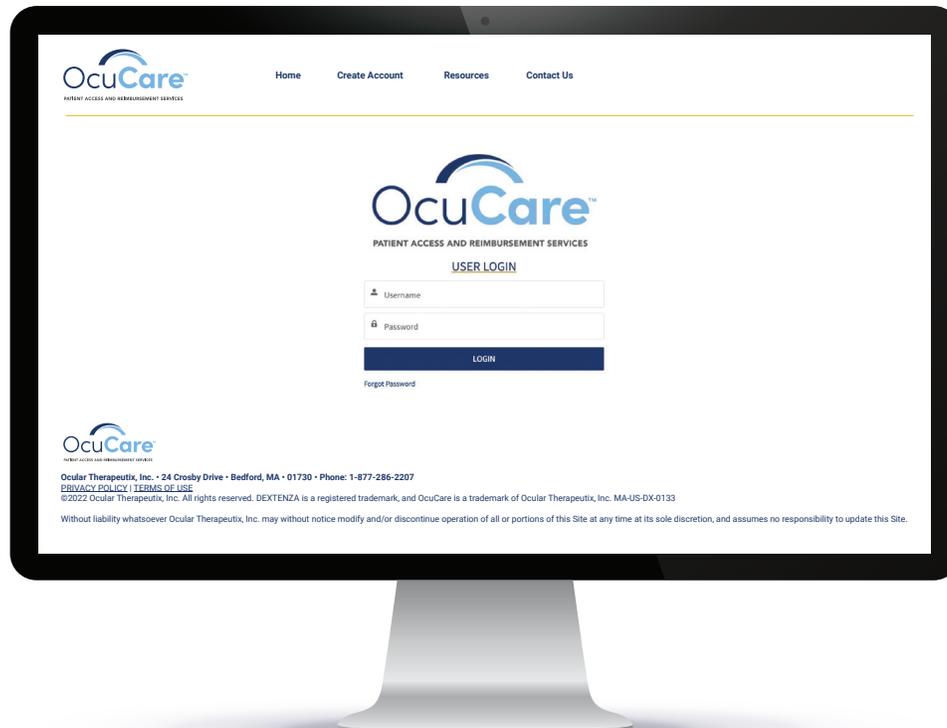
Create an account to seamlessly access your dedicated resource and support team.

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



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

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.

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

●

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

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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.



Benefits Identification 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



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

PRIMARY MEDICAL **2**

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



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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.

Sample CMS Forms for DEXTENZA



IN THE OFFICE

- Professional CMS-1500 Claim Form for Post-Surgical DEXTENZA Insertion in the Office Setting
- Professional CMS-1500 Claim Form for DEXTENZA Insertion for Non-Surgical Purposes in the Office Setting



IN THE OPERATING ROOM ASC/HOPD

- Professional CMS-1500 Claim Form for Post-Surgical DEXTENZA Insertion in the ASC/HOPD
- Facility CMS-1500 Claim Form for Post-Surgical DEXTENZA Insertion in ASC/HOPD
- Facility CMS-1450 Claim form for DEXTENZA Insertion in HOPD



Click, Call, or Connect [MyOcuCare.com](https://www.mycare.com)



Facility CMS-1500 Claim Form for Post-Surgical DEXTENZA Insertion in ASC

Box 21

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

Box 21

Enter "0" for ICD-10-CM.

Box 24B

Enter "24" for ASC.

Box 24A

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

Box 24D

Enter the CPT‡ code for the surgical procedure (e.g., 66984), HCPCS code to represent DEXTENZA (J1096) and the relevant modifiers.

****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 code (66984). 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

1. MEDICARE (Medicare) MEDICAID (Medicaid) TRICARE (DoD) CHAMPVA (Member DoD) GROUP HEALTH PLAN (DoD) FECA (FECA) UNEMP (Unemp) OTHER (Other)

1a. INSURED'S I.D. NUMBER: 123 45 6789A

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

3. PATIENT'S BIRTH DATE: MM DD YY: 01 01 22

4. INSURED'S NAME (Last Name, First Name, Middle Initial): 123 Anystreet, Anytown, MA 12345

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

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 123 Anystreet, Anytown, MA 12345

8. RESERVED FOR NUCC USE

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

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: [Signature]

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: [Signature]

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP): MM DD YY: 01 01 22

15. OTHER DATE: MM DD YY: 01 01 22

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY: 01 01 22 TO 01 01 22

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: [Name]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY: 01 01 22 TO 01 01 22

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO \$ CHARGES: 0

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to service line below (24E)) ICD Incl. 0: XX X

22. RESUBMISSION CODE: 1

23. PRIOR AUTHORIZATION NUMBER

24. A.	DATE(S) OF SERVICE	B.	FACTOR SERVICE	C.	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	D.	MODIFIER	E.	DIAGNOSIS POINTER	F.	\$ CHARGES	G.	\$ AMOUNT PAID	H.	RENDERING PROVIDER ID #
1	01 01 22	01	01	22	24	66984	A	XXX	XX	1	NPI	1234567890			
2	N470382020401 UN1		01	01	22	J1096	A	XXX	XX	4	NPI	1234567890			
3											NPI				
4											NPI				
5											NPI				
6											NPI				

25. FEDERAL TAX I.D. NUMBER: [Blank]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE: \$

29. AMOUNT PAID: \$

30. Rev'd for NUCC Use

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

32. SERVICE FACILITY LOCATION INFORMATION: Any ASC, 123 Anystreet, Anytown, MA 12345

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

SIGNED: [Signature] DATE: [Blank]

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

*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 Claim Form for Post-Surgical DEXTENZA Insertion in the Operating Room

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

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (DoD) CHAMPVA (Member DoD) GROUP HEALTH PLAN (ID#) FECA (FECA#) (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER: **123 45 6789A**

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

3. PATIENT'S BIRTH DATE: MM/DD/YY: **MM XX YY** SEX: M 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: Spouse Spouse Child Other

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

8. RESERVED FOR NUCC USE

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:

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: **SMITH JOHN A.**

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: **SMITH JOHN A.**

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP): MM/DD/YY: **MM XX YY**

15. OTHER DATE: QUAL: MM/DD/YY: **MM XX YY**

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: **SMITH JOHN A.**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM/DD/YY 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: ICD-10: **XX^X^X**

22. RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A.	DATE(S) OF SERVICE	B.	PROCEDURE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	E.	F.	G.	H.	I.	J.
MM	DD	YY	MM	DD	YY	QUAL	MODIFIER	CHARGES	UNIT	DIAGNOSIS	RENDERING PROVIDER ID #
01	01	22	01	01	22	24	66984		1	A	NPI 1234567890
01	01	22	01	01	22	24	68841		1	A	NPI 1234567890

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

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE: \$

29. AMOUNT PAID: \$

30. Place for NUCC Use:

31. SIGNATURE OF PHYSICIAN OR SUPPLIER: **Any ASC**

32. SERVICE FACILITY LOCATION INFORMATION: **123 Anystreet, Anytown, MA 12345**

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

SIGNED: **NPI** DATE: **NPI**

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Facility CMS-1450 Claim form for DEXTENZA Insertion in ASC/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).

1 Any Hospital 123 Any Street Any Town, MA 12345		2 Any Hospital 123 Any Street Any Town, MA 12345		3 1234		4 0131	
8 PATIENT NAME Doe, John		9 PATIENT ADDRESS 123 Any Street		10 BIRTHDATE 02/21/1954		11 SEX M	
12 ADMISSION DATE 01		13 HR. 14 TYPE 15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
42 REV. CD. 43 DESCRIPTION		44 HCPCS / RATE / HPPS CODE		45 SERVL DATE		46 SERVL UNITS	
1 Cataract Surgery		66984		1/1/22		1	
2 DEXTENZA Administration		68841		1/1/22		1	
3 DEXTENZA Insert		J1096		1/1/22		4	
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Professional CMS-1500 Claim Form for Post-Surgical DEXTENZA Insertion in the Office Setting

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).

*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.

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HCPCS = Healthcare Common Procedure Coding System.

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

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.

*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.

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

1. MEDICARE (Medicare#) MEDICAID (Di#(DiDt)) TRICARE (Di#(DiDt)) CHAMPVA (Member Dt) GROUP HEALTH PLAN (Dt) FECA (FECA) (Dt) OTHER (Dt)

1a. INSURED'S I.D. NUMBER: 123 45 6789A

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

3. PATIENT'S BIRTH DATE: MM DD YY: M X | D | Y Y

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

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

6. PATIENT RELATIONSHIP TO INSURED: Spouse Spouse Child Other

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

8. RESERVED FOR NUCC USE

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:

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP): MM DD YY

15. OTHER DATE: MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY 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: ICD-10: 01012201012211

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. PROCEDURE CODE(S) C. DIAGNOSIS POINTER

MM	DD	YY	MM	DD	YY	PROCEDURE CODE(S)	DIAGNOSIS POINTER	F. \$ CHARGES	G. \$ AMOUNT PAID	H. ID QUAL	I. RENDERING PROVIDER ID #
01	01	22	01	01	22	11	68841	A	XXX XX	2	NPI 1234567890
01	01	22	01	01	22	11	J1096	A	XXX XX	8	NPI 1234567890

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

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE: \$

29. AMOUNT PAID: \$

30. Rev'd for NUCC Use

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

32. SERVICE FACILITY LOCATION INFORMATION: Any Office, 123 Anystreet, Anytown, MA 12345

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

SIGNED: NPI DATE: NPI

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

IMPORTANT SAFETY INFORMATION

INDICATIONS

DEXTENZA is a corticosteroid indicated for:

- The treatment of ocular inflammation and pain following ophthalmic surgery.
- The treatment of ocular itching associated with allergic conjunctivitis.

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

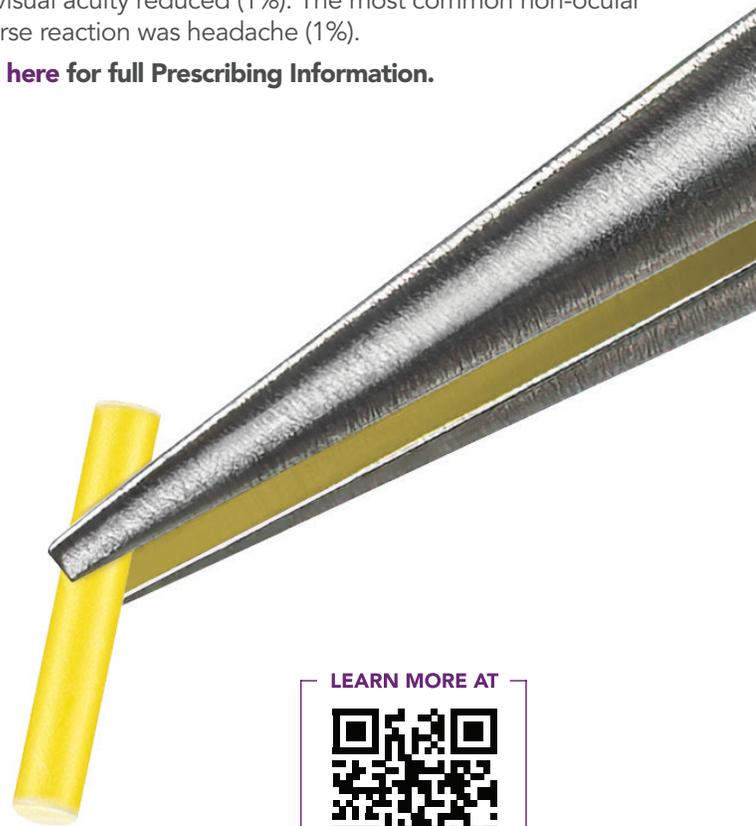
Ocular Inflammation and Pain Following Ophthalmic Surgery

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.](#)



LEARN MORE AT



DEXTENZA.COM



PATIENT ACCESS AND REIMBURSEMENT SERVICES

