Dextenza 360™
Patient Access and Reimbursement Services

REIMBURSEMENT GUIDEBOOK

This guide provides reimbursement information for DEXTENZA, including sample claim forms, and how DEXTENZA360 can provide seamless support throughout the process for DEXTENZA.

Click, Call, or Connect DEXTENZA360
Technical Support 877-286-2207

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

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(dexamethasone ophthalmic insert) 0.4 mg
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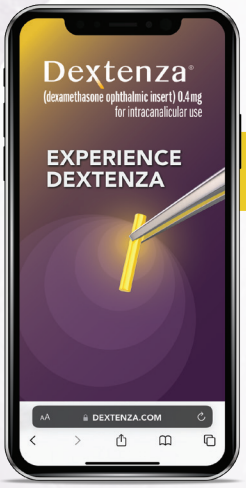

Connect to Us

www.dextenza.com

www.twitter.com/OCUTX

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

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THE ROLE OF DEXTENZA360 IN PATIENT ACCESS TO DEXTENZA

Dextenza®
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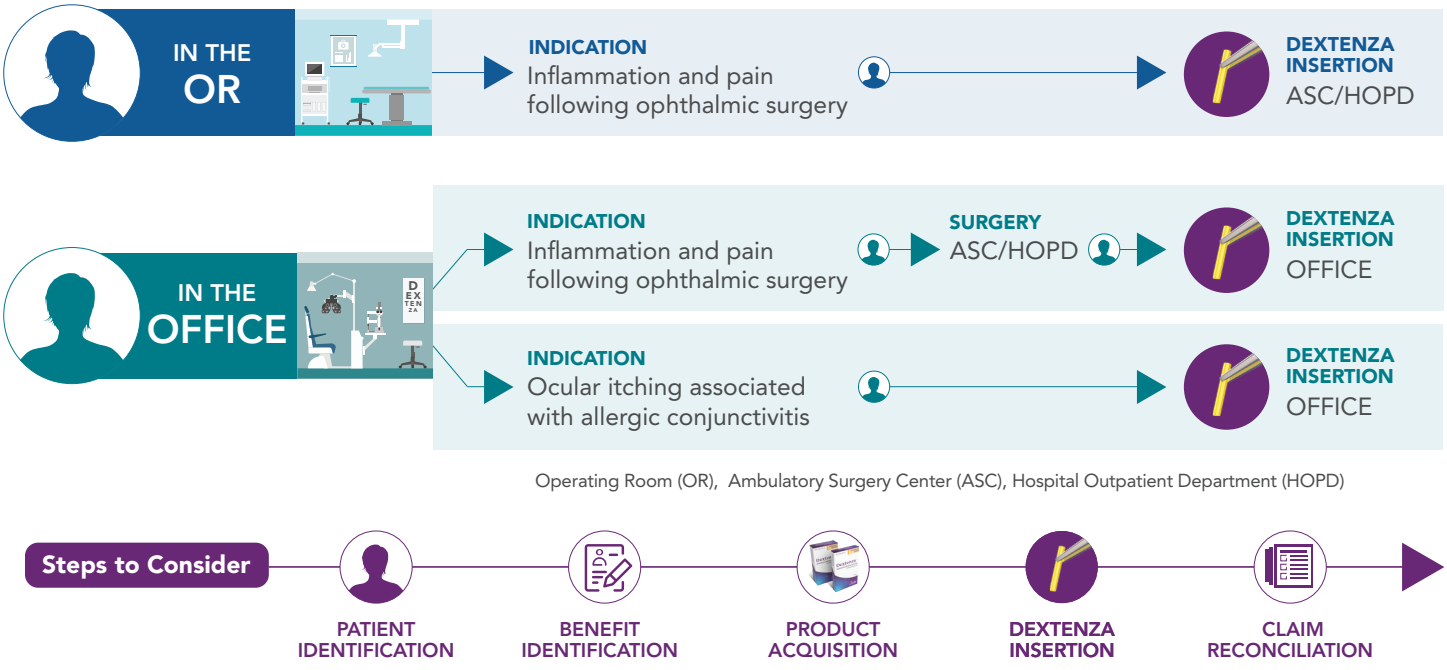
Dextenza Patient Journey



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, DEXTENZA360 case manager, and field reimbursement manager. Our Medical Affairs team is also available to assist with any questions.

Dextenza 360™
Patient Access and Reimbursement Services

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

Reimbursement Roadmap

WE RECOGNIZE THAT EVERY CARE SETTING IS UNIQUE.

We support you and your team with your specific needs.

1. **Initial patient visit and diagnosis**
2. **Register or login at DEXTENZA360.com** to access the portal with tools, forms, and resources, or to speak with your Field Reimbursement Manager.
3. **Investigate benefits through DEXTENZA360** to confirm coverage and identify any criteria or restrictions. Patient may qualify for financial assistance, if needed.
4. **Order DEXTENZA (dexamethasone ophthalmic insert)** through specialty distributors.
5. **DEXTENZA insertion**
6. **After administering DEXTENZA, submit claim** to the plan for DEXTENZA and the procedure using a CMS-1500 or CMS-1450 Form. If applicable, the patient's out-of-pocket is collected by the provider.
7. **Reconcile and confirm reimbursement** with support from your Field Reimbursement Manager or **DEXTENZA360.**

This information is provided for general informational purposes and is not a directive, guarantee of coverage, or a substitute for an independent clinical decision.

Click, Call, or Connect DEXTENZA360
Technical Support 877-286-2207

Dextenza 360
Patient Access and Reimbursement Services

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How to Order DEXTENZA

Contact one of our authorized distributors listed below to order DEXTENZA and receive it by the next business day.

Distributor	Phone	Fax	Website
Besse Medical	1-800-543-2111	1-800-543-8695	besse.com
Cardinal Specialty Pharma Distribution	1-855-855-0708	1-614-553-6301	cardinalhealth.com/specialtyonline
FFF Enterprises	1-800-843-7477	1-800-418-4333	fffenterprises.com
Metro Medical	1-800-768-2002	1-615-256-4194	metromedicalorder.com
McKesson Medical-Surgical	1-855-571-2100	1-800-311-3408	mms.mckesson.com
McKesson Plasma and Biologics for Hospitals	1-877-625-2566	1-888-752-7626	connect.mckesson.com

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 supplied[1]

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 handling[1]

- 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.

Product and Procedure Billing Codes

Product Reimbursement

As of January 1, 2023, 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-10/2022-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 approrpriate 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

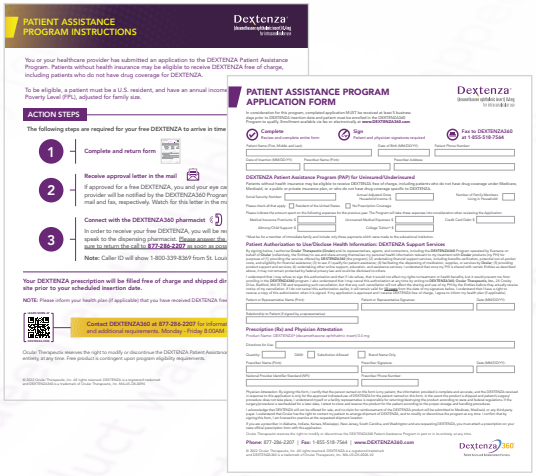
TIP TO REMEMBER

Customers are responsible for determining the approrpriate coding and submission of accurate claims.

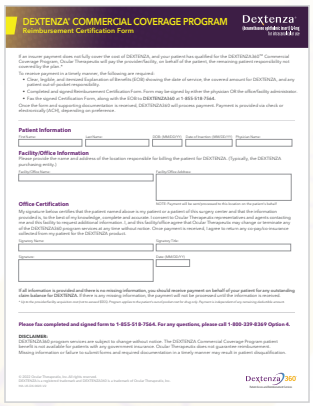
Find more information about HCPCS codes at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

AVAILABLE PATIENT AND PRODUCT PROGRAMS

There are three available programs offered currently for DEXTENZA



PATIENT ASSISTANCE PROGRAM (PAP)



COMMERCIAL COVERAGE PROGRAM

PRODUCT REPLACEMENT PROGRAM

Information on all these programs is available on **www.DEXTENZA.com** or **www.DEXTENZA360.com**

Click, Call, or Connect DEXTENZA360 Technical Support 877-286-2207

Patient Assistance Program (PAP) Application Information

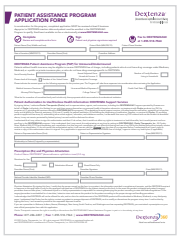
You or your healthcare provider has submitted an application to the DEXTENZA Patient Assistance Program. Patients without health insurance may be eligible to receive DEXTENZA free of charge, including patients who do not have drug coverage for DEXTENZA.

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**


PATIENT ASSISTANCE PROGRAM
APPLICATION FORM

2 — **Receive approval letter in the mail**

If approved for a free DEXTENZA, you and your eye care provider will be notified by the DEXTENZA360 Program via mail and fax, respectively. Watch for this letter in the mail.

3 — **Connect with the DEXTENZA360 pharmacist**

In order to receive your free DEXTENZA, you will be required to speak to the dispensing pharmacist. Please answer the call or be sure to return the call to **877-286-2207** as soon as possible.

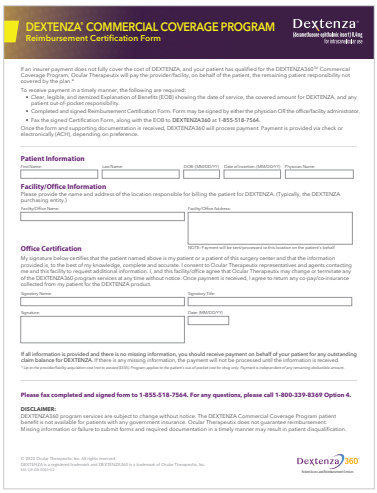
Note: Caller ID will show 1-800-339-8369 from St. Louis, Missouri.

Your DEXTENZA prescription will be filled free of charge and shipped directly to the insertion site prior to your scheduled insertion date.

NOTE: Please inform your 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.

Commercial Coverage Program Overview and Criteria



DEXTENZA® COMMERCIAL COVERAGE PROGRAM
Reimbursement Certification Form

Dextenza®
(dexamethasone ophthalmic insert) 0.4mg
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 provided facility acquisition cost (not to exceed $550). 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.

MAT-US-DXZ-0222-V2

Dextenza360™
Patient Access and Reimbursement Services

Financial assistance with out-of-pocket costs for qualifying patients:

- For eligible patients with commercial insurance, Ocular Therapeutix covers the patient's responsibility for DEXTENZA.
- This program is not designed to cover underpayment, bundling or groupings.

Commercial Criteria

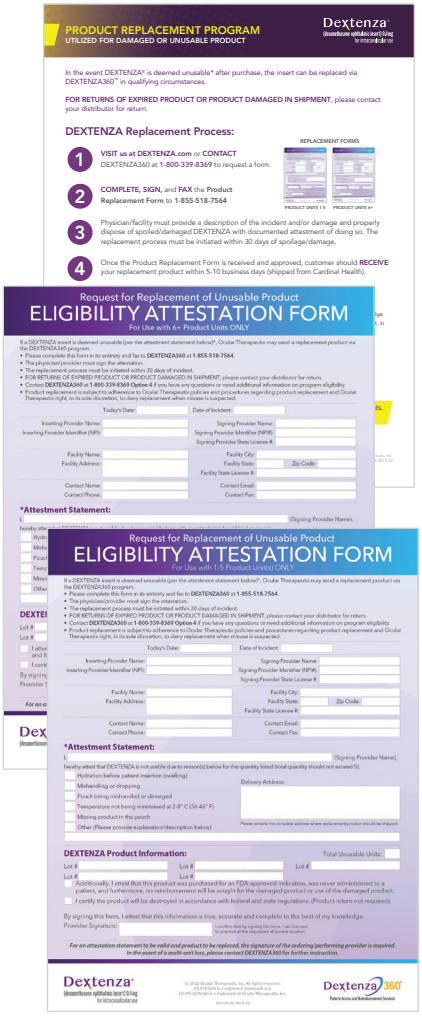
- US resident with a legal US mailing address.
- Enrolled in DEXTENZA360 by the healthcare provider or site of care.
- Must have a commercial insurance plan, not government insurance, i.e. Medicare, Medicaid, Medicare Advantage and TriCare.
- Diagnosis that meets the product label requirements.
- Benefit is capped at the Facility Acquisition Cost.
- Underpayments, bundling and group claims do not qualify for this program.
- Invoice must be included with request.

TIP TO REMEMBER

Bundling and underpayments do not qualify for this program.

Product Replacement Program Overview and Criteria

In the event DEXTENZA is deemed unusable* after purchase, the insert can be replaced via DEXTENZA360 in qualifying circumstances.



Product replacement for DEXTENZA inserts rendered unusable:

- Place a formal request with the Product Replacement Form, located on www.DEXTENZA.com or available from your local Field Reimbursement Manager.
- FOR RETURNS OF EXPIRED PRODUCT OR PRODUCT DAMAGED IN SHIPMENT, please contact your distributor for return.

Program Eligibility Criteria

- 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.
- Product replacement request must be submitted 30 days from the date of incident.

*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.

Product Replacement Program Overview and Criteria

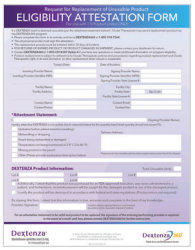
FOR RETURNS OF EXPIRED PRODUCT OR PRODUCT DAMAGED IN SHIPMENT, please contact your distributor for return.

DEXTENZA Replacement Process:

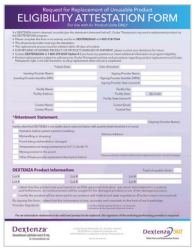
1. **VISIT www.DEXTENZA.com** or **www.dextenza360.com** or **PHONE 877-286-2207** to request a form.

2. **COMPLETE, SIGN,** and **FAX** the **Product Replacement Form** to **1-855-518-7564**

REPLACEMENT FORMS



PRODUCT UNITS 1-5



PRODUCT UNITS 6+

3. Physician/facility must provide a description of the incident and/or damage and properly dispose of spoiled/damaged DEXTENZA with documented attestment 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.

Click, Call, or Connect DEXTENZA360
Technical Support 877-286-2207

Comprehensive Support With DEXTENZA360

YOU AND YOUR PATIENTS - AT THE CENTER OF OUR DEXTENZA360 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. DEXTENZA360 will help determine patient eligibility and investigate options.

MAKING DEXTENZA360 SUPPORT CONVENIENT FOR YOU

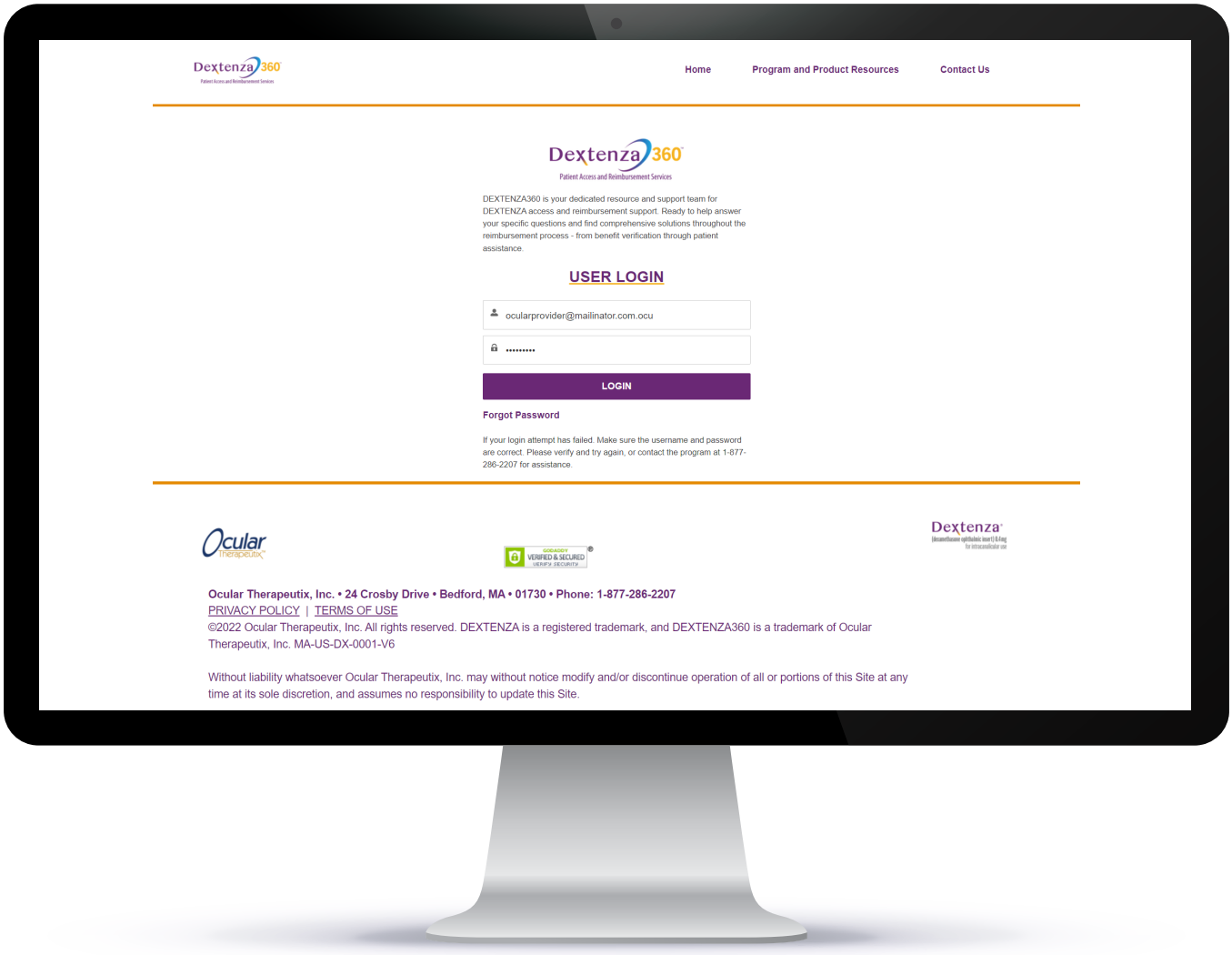
Click, Call, or Connect DEXTENZA360
Technical Support 877-286-2207

DEXTENZA360 Portal

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

Key Features

- Enroll your practice
- Enroll new patients
- View the status of patients enrolled online and by fax
- View benefit summary details
- Electronic and faxed submissions will appear in the portal



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

DEXTENZA360 Patient Enrollment Form

The support you need starts with this simple form. The **DEXTENZA360 Patient Enrollment Form** allows you to request a wide range of resources to support you and your DEXTENZA patients.

Important Reminders

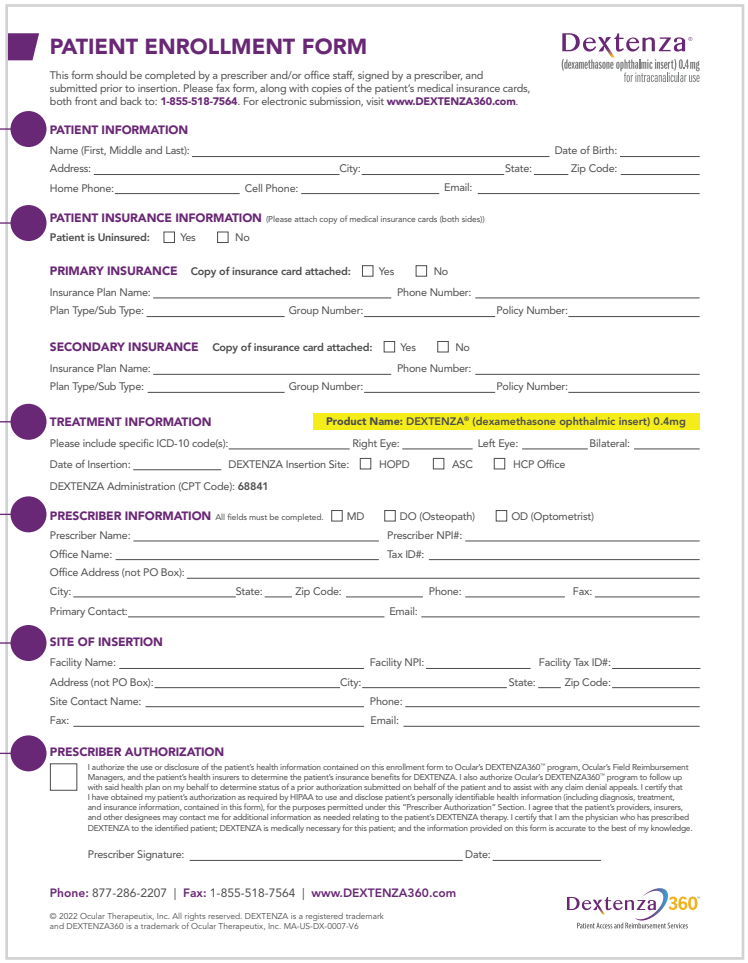
- Provider must sign
- Allows you to select what services you would like for each patient
- Please send to DEXTENZA360 five (5) business days prior to insertion
- Can be faxed or sent electronically to DEXTENZA360

Provide patient and insurance information

Complete treatment information section

Complete site of care information

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



PATIENT ENROLLMENT FORM

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

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.DEXTENZA360.com**.

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#: _____
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 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: _____

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

Dextenza 360™ Patient Access and Reimbursement Services

Submit the form via www.DEXTENZA360.com* or fax 1-855-518-7564

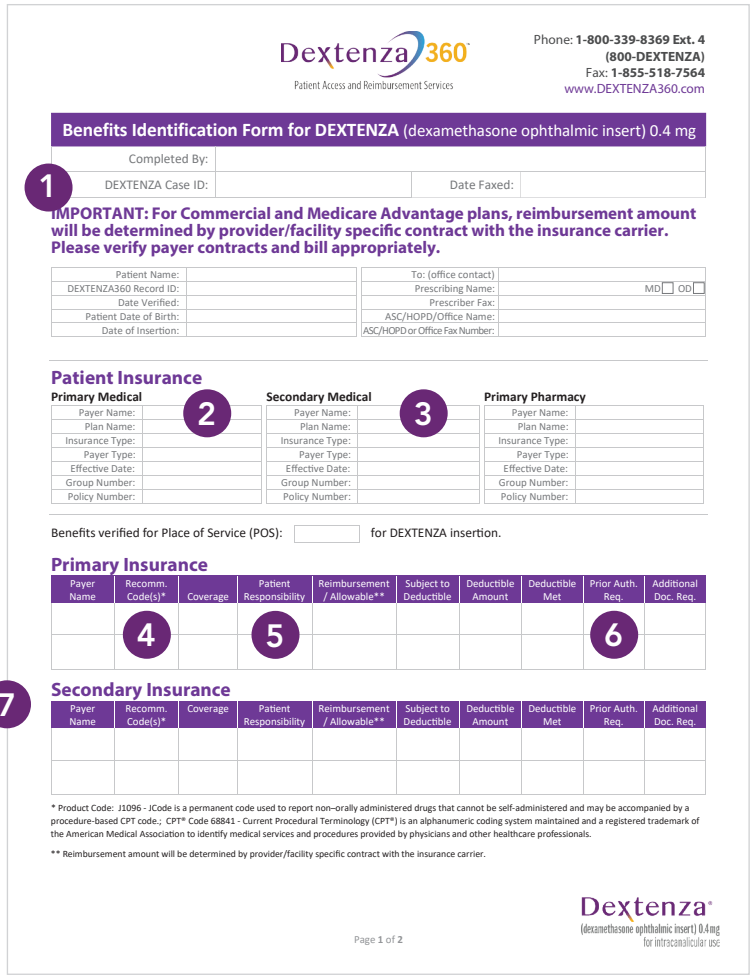
*A secure, online portal and convenient option to enroll and manage patients in DEXTENZA360 support programs. Provides instant access to patient case status updates 24 hours a day, 7 days a week. Registration Required.

Dextenza 360™
Patient Access and Reimbursement Services

Benefits Identification Form

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

1. **DEXTENZA360 Case ID:** Refer to this number when speaking to your DEXTENZA360 Case Manager
2. **Primary Medical:** DEXTENZA360 will contact to verify patient's insurance coverage
3. **Secondary Medical:** DEXTENZA360 will contact both payers (if applicable) to verify patient's 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



Dextenza 360
Patient Access and Reimbursement Services

Phone: **1-800-339-8369 Ext. 4**
(800-DEXTENZA)
Fax: **1-855-518-7564**
www.DEXTENZA360.com

Benefits Identification Form for DEXTENZA (dexamethasone ophthalmic insert) 0.4 mg

Completed By:			
DEXTENZA Case ID:		Date Faxed:	

IMPORTANT: For Commercial and Medicare Advantage plans, reimbursement amount will be determined by provider/facility specific contract with the insurance carrier. Please verify payer contracts and bill appropriately.

Patient Name:		To: (office contact)	
DEXTENZA360 Record ID:		Prescribing Name:	MD ☐ OD ☐
Date Verified:		Prescriber Fax:	
Patient Date of Birth:		ASC/HOPD/Office Name:	
Date of Insertion:		ASC/HOPD or Office Fax Number:	

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	Recomm. Code(s)*	Coverage	Patient Responsibility	Reimbursement / Allowable**	Subject to Deductible	Deductible Amount	Deductible Met	Prior Auth. Req.	Additional Doc. Req.

Secondary Insurance

Payer Name	Recomm. Code(s)*	Coverage	Patient Responsibility	Reimbursement / Allowable**	Subject to Deductible	Deductible Amount	Deductible Met	Prior Auth. Req.	Additional Doc. Req.

* Product Code: J1096 - JCode is a permanent code used to report non–orally administered drugs that cannot be self-administered and may be accompanied by a procedure-based CPT code.; CPT® Code 68841 - Current Procedural Terminology (CPT®) is an alphanumeric coding system maintained and a registered trademark of the American Medical Association to identify medical services and procedures provided by physicians and other healthcare professionals.

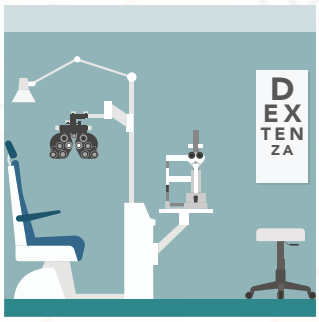
** Reimbursement amount will be determined by provider/facility specific contract with the insurance carrier.

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

Page 1 of 2

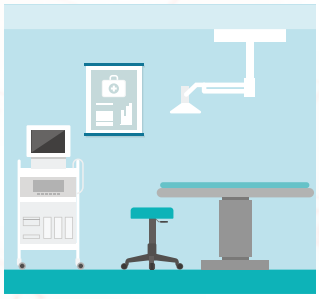
NOTE: The Benefits Summary Form is not a guarantee of insurance coverage. All benefits are subject to the insured's plan at the time services are rendered. Under no circumstances shall DEXTENZA360 be held responsible or liable for payment of any claims, benefits, or costs.

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 DEXTENZA360
Technical Support 877-286-2207

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.

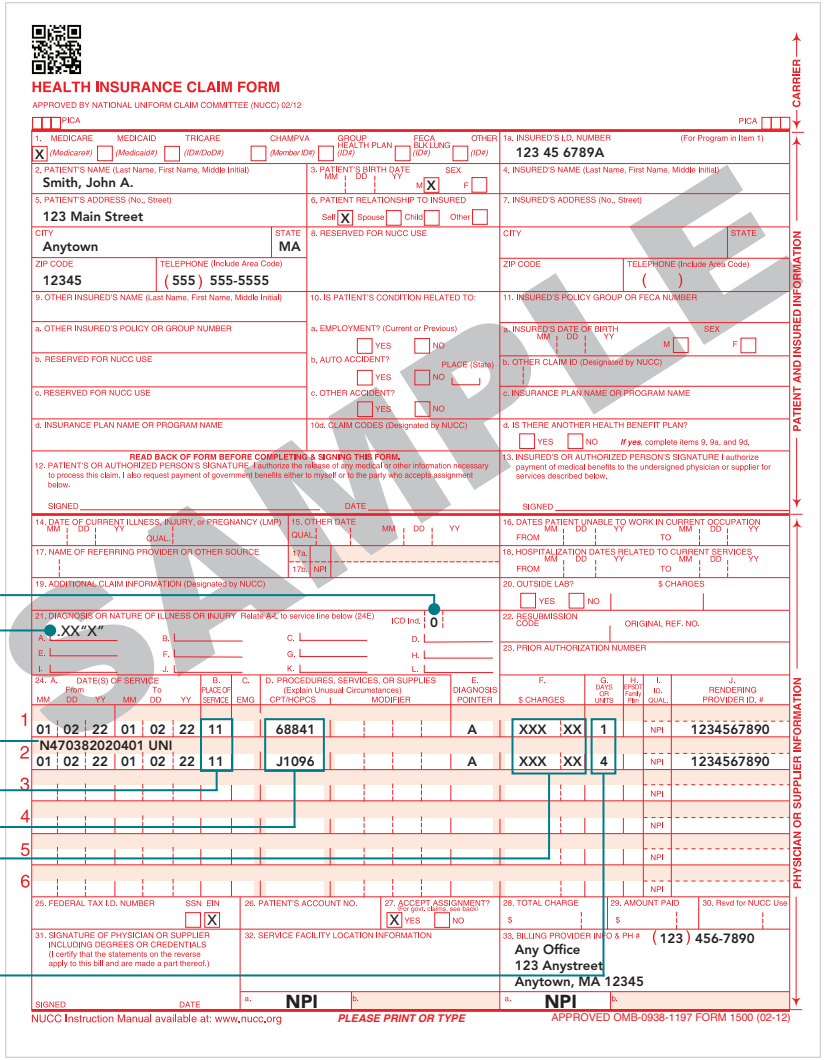
Box 24A
Enter N4 qualifier and 11-digit NDC code: N470382020401 UN1.†

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.

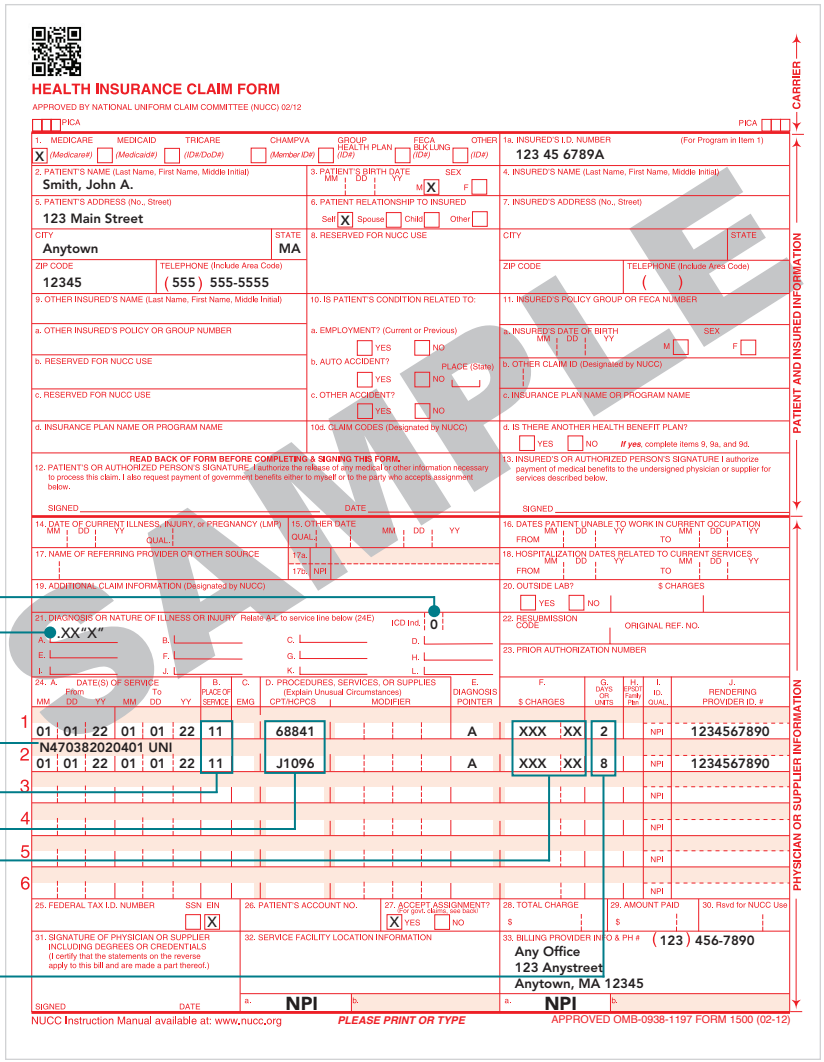
Box 24A
Enter N4 qualifier and 11-digit NDC code: N470382020401 UN1.†

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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Professional CMS-1500 Claim Form for Post-Surgical DEXTENZA Insertion in the Operating Room

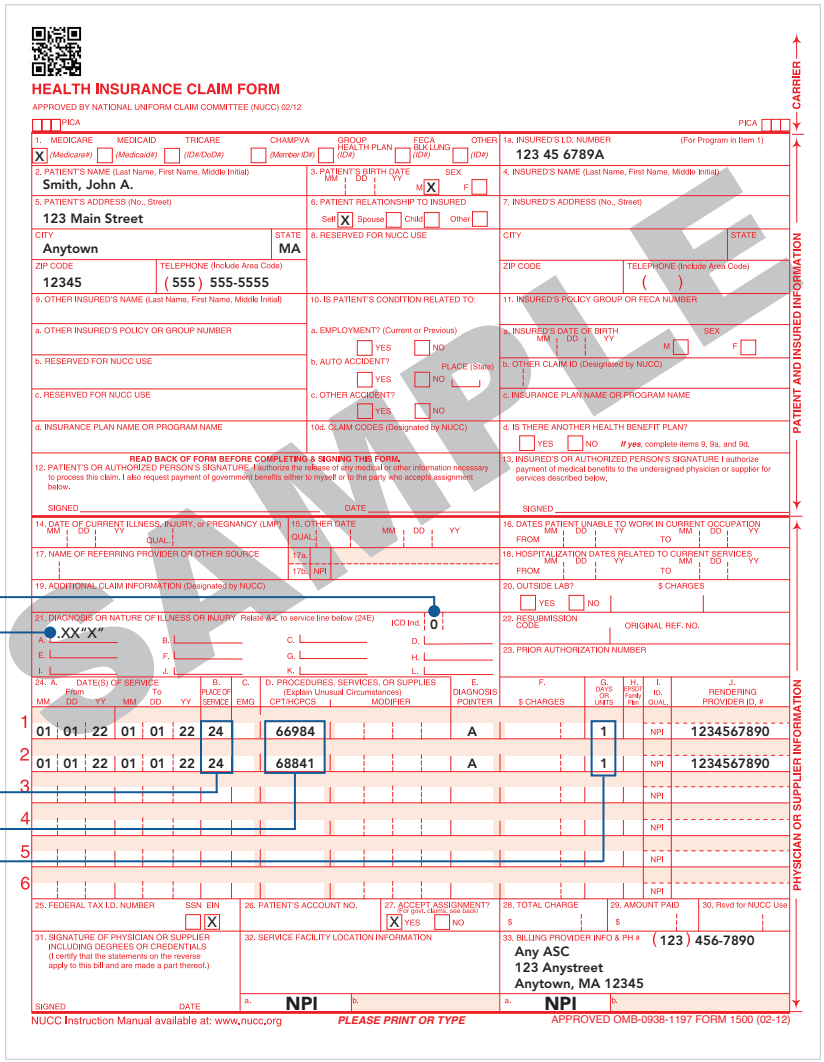
Box 21
Enter the appropriate ICD*-10 code(s).

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 DEXTENZA insertion (68841), HCPCS code to represent DEXTENZA (J1096) 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

PICA

1. MEDICARE X (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123 45 6789A

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

3. PATIENT'S BIRTH DATE MM DD YY | SEX M X 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: Self X Spouse Child Other

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

CITY: Anytown | STATE: MA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE | TELEPHONE (Include Area Code): ( )

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

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

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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 Relate A-L to service line below (24E) ICD Ind. 0

A. .XX"X" B. C. D.

E. F. G. H.

I. J. K. L.

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. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 22	01 01 22	24		66984		A		1	NPI	1234567890
2	01 01 22	01 01 22	24		68841		A		1	NPI	1234567890
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

Any ASC
123 Anystreet
Anytown, MA 12345

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

*International Classifications of Diseases (ICD).

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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.

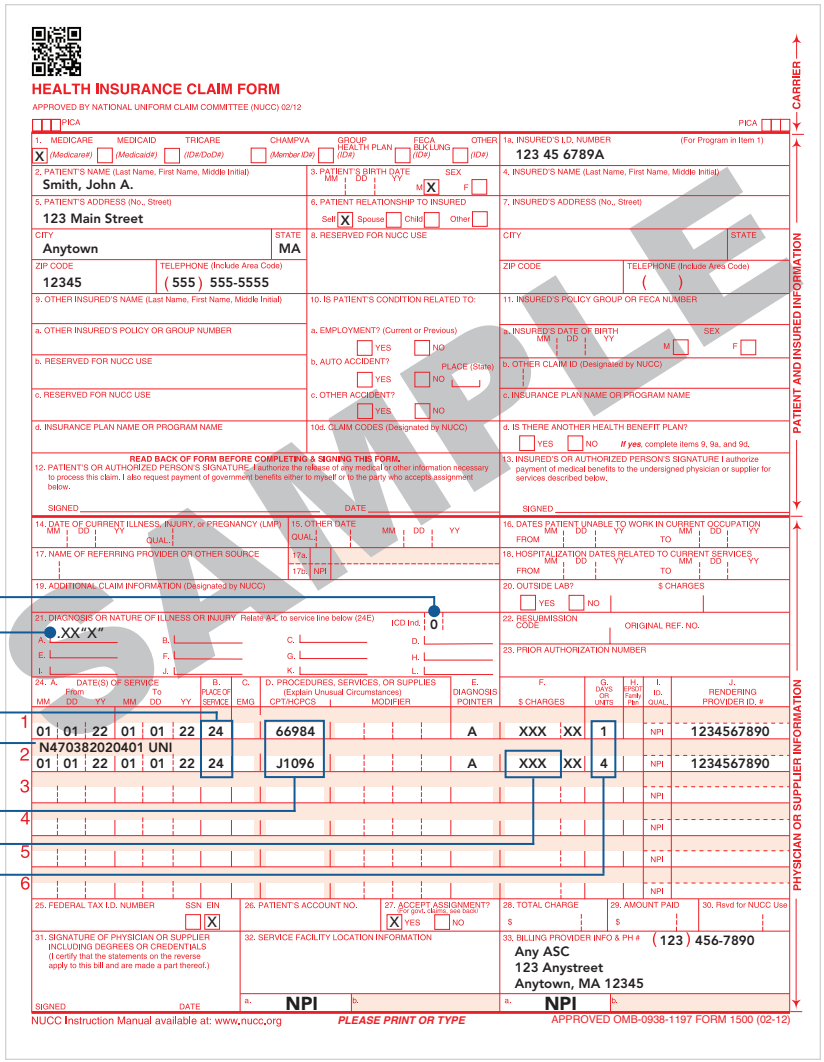
Box 24B
Enter "24" for ASC.

Box 24A
Enter N4 qualifier and 11-digit NDC code: N470382020401 UN1.†

Box 24D
Enter the CPT‡ code for DEXTENZA insertion (68841), 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 codes (66984 and 68841). 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

PICA

1. MEDICARE X (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

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3. PATIENT'S BIRTH DATE MM DD YY | SEX M X 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: Self X Spouse Child Other

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

CITY: Anytown | STATE: MA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (555) 555-5555

ZIP CODE | TELEPHONE (Include Area Code)

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

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

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A .XX"X" B. C. D.

E. F. G. H.

I. J. K. L.

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. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 22	01 01 22	24		66984		A	XXX	XX	1	NPI	1234567890
2	N470382020401 UNI 01 01 22	01 01 22	24		J1096		A	XXX	XX	4	NPI	1234567890
3											NPI	
4											NPI	
5											NPI	
6											NPI	

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

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

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

Any ASC
123 Anystreet
Anytown, MA 12345

a. NPI b.

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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†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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Facility CMS-1450 Claim form for DEXTENZA Insertion in HOPD

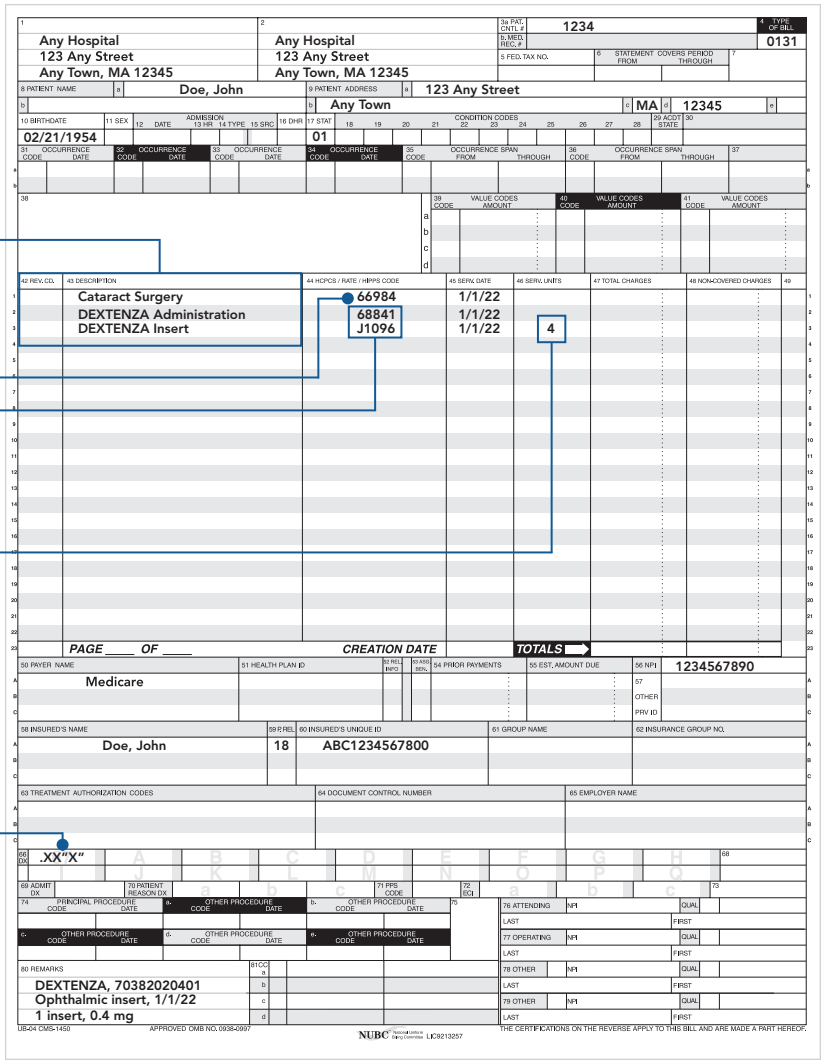
Box 42, 43
Enter revenue code and revenue code description for the type of ophthalmic surgery (e.g., cataract, as shown here) and DEXTENZA.

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).



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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

Dextenza 360™

Patient Access and Reimbursement Services

ORDERING AND

REIMBURSEMENT

Ocular Therapeutix™