

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

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



Connect to Us

www.dextenza.com



www.twitter.com/OCUTX



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

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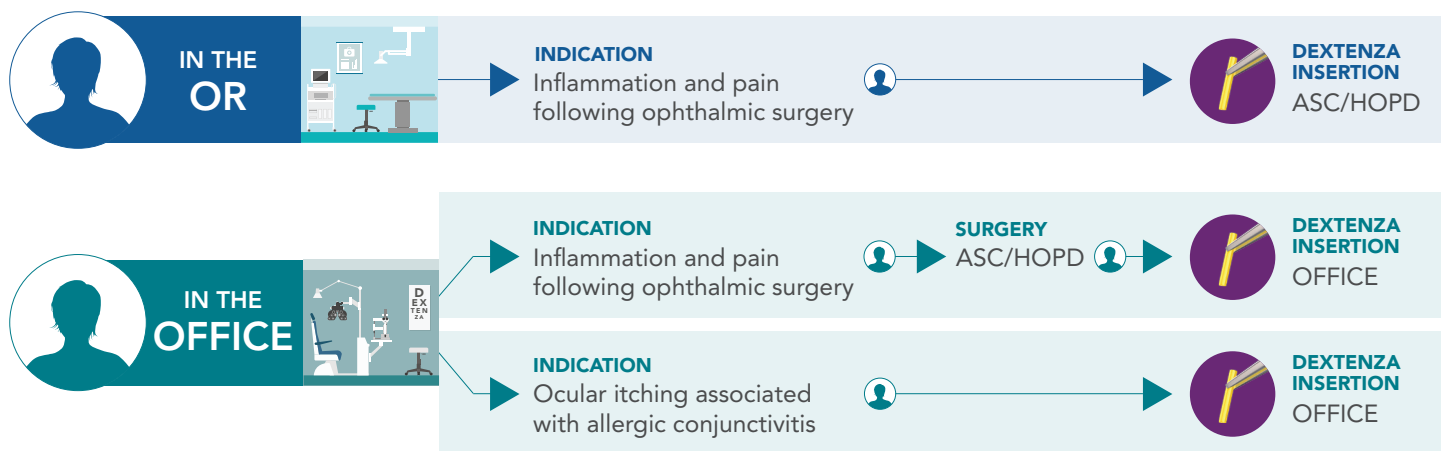
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THE ROLE OF DEXTENZA360 IN PATIENT ACCESS TO DEXTENZA

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

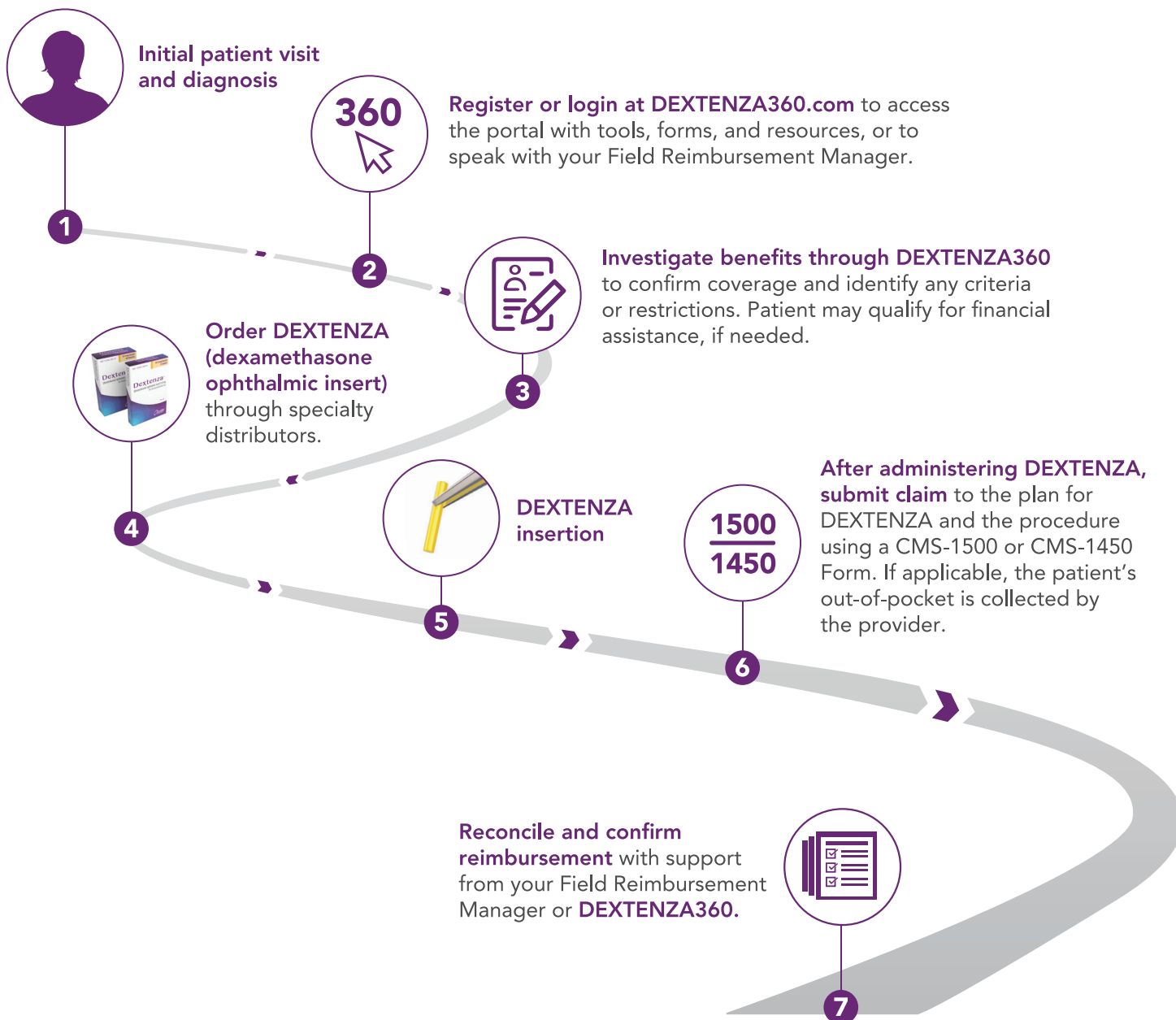


Your dedicated DEXTENZA team consists of a national account director, key account manager, medical director, DEXTENZA360 case manager, and field reimbursement manager. Our Medical Affairs team is also available to assist with any questions.

Reimbursement Roadmap

WE RECOGNIZE THAT EVERY CARE SETTING IS UNIQUE.

We support you and your team with your specific needs.



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

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 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

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)

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
Ocular pain	H57.1	H57.11	H57.12	H57.13	H57.14
Contact extraction status	Z98.4	Z98.41	Z98.42	-	Z98.43
Presence of intraocular lens;	Z96.1	-	-	-	-
Pseudophakia	H25.01	H25.011	H25.012	H25.013	H25.014
Other acute postoperative conjunctivitis	-	-	-	-	-

* 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 Associated with Allergic Conjunctivitis

Allergic Conjunctivitis	General	Right Eye	Left Eye	Bilateral
Acute atopic conjunctivitis	H10.1	H10.11	H10.12	H10.13
Chronic atopic conjunctivitis	H10.3	H10.31	H10.32	H10.33
Other acute postoperative conjunctivitis	H10.4	H10.41	H10.42	H10.43
Other chronic postoperative conjunctivitis	H10.41	H10.411	H10.412	H10.413

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 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/HCPSCReleaseCodeSets/HCPSC-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/HCPSCReleaseCodeSets/HCPSC-Quarterly-Update>

Dextenza®

(dexamethasone ophthalmic insert) 0.4 mg
for intracanalicular use

PATIENT ASSISTANCE PROGRAM INSTRUCTIONS

Yes 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 through a health plan.

To be eligible, a patient must be a U.S. resident, and have an annual income (Power) Level (PFL) applicable for family size.

ACTION STEPS

The following steps are required for your free DEXTENZA to arrive in time for your scheduled injection date.

1

Complete and return form

2

Receive approval letter in the mail

If approved for free DEXTENZA, you and your care team will be notified by the following approval letter and fax, respectively. Watch for this letter in the mail.

3

Connect with DEXTENZA pharmacist

In order to receive your free DEXTENZA, you will be required to discuss your program with a pharmacist. Please contact us at info@dexenza.com or 1-800-339-2207 for assistance.

Note: Call or visit us at 1-800-339-2207 from St. Louis.

Your DEXTENZA prescription will be filled free of charge and shipped **direct** to you prior to your scheduled injection date.

NOTE: Please allow your health plan (if applicable) that you have received DEXTENZA free of charge.

Contact DEXTENZA at 877-985-2767 for status and additional requirements. **Printed Form 6/2024**

Caution: Therapeutic misuse is the right to modify or discontinue the DEXTENZA Patient Assistance program at any time. Please contact appropriate program eligibility representative.

1

DEXENZA

DEXENZA is a registered trademark of Dextenza, Inc.

PATIENT ASSISTANCE PROGRAM APPLICATION FORM

A completed application form must be received by DEXTENZA no later than 7 business days prior to your scheduled injection date. Please allow 10 business days for processing.

Complete

Print your name and address below:

First Name: _____

Last Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Fax: _____

E-mail: _____

Health Insurance: _____

Insurance ID: _____

Insurance Type: _____

Insurance Plan: _____

Insurance Group: _____

Insurance Policy: _____

Insurance Provider: _____

Insurance Agent: _____

Insurance Broker: _____

Insurance Company: _____

Insurance Plan: _____

Insurance ID: _____

Insurance Type: _____

Insurance Plan: _____

Insurance ID: _____

Insurance Type: _____

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Insurance Type: _____

Insurance Plan: _____

Insurance ID: _____

Insurance Type: _____

Insurance Plan: _____

Insurance ID: _____

Sign

Print your signature and date below:

Signature: _____

Date: _____

Print Name: _____

Print Address: _____

Print City: _____

Print State: _____

Print Zip: _____

Print Phone: _____

Print Fax: _____

Print E-mail: _____

Print Health Insurance: _____

Print Insurance ID: _____

Print Insurance Type: _____

[illegible]

COMMERCIAL COVERAGE PROGRAM

[illegible]

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

PRODUCT REPLACEMENT PROGRAM



10

Dextenza 360™
Patient Access and Reimbursement Services

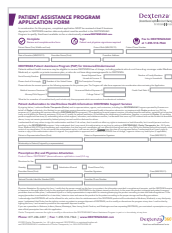
Patient Assistance Program (PAP) Application Information

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****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.

DENTENZA[®] COMMERCIAL COVERAGE PROGRAM

Reimbursement Certification Form



Interim HealthCare Inc.
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If a new member does not yet have one of our DENTENZA[®] and/or patient has not qualified for the DENTENZA[®] Commercial Coverage Program, Dentenza[®] Patient Support will provide the process/flow, including the patient's, the managing provider's responsibility to receive payment in a timely manner, the following are required:

- Completed and signed Request for Benefit (Dentenza[®] Form 1) and the claim, consent form to DENTENZA[®], and a patient not under a coordination of benefits.
- Completed and signed Reimbursement Certification Form. Forms may be signed by the physician OR the facility's administrator.
- Fax to designated Certification Form, along with the EOB: DENTENZA[®] 300-1 855-516-7564.

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

Patient Information

Name	DOB	Address - ZIP/State	Patient Name

Facility/Office Information

Facility/Office Name and address of the location responsible for billing the patient for DENTENZA[®]. (Typically, the DENTENZA[®] purchasing entity.)

Facility/Office Name	Facility/Office Address

Office Certification

We, the undersigned, hereby certify that the patient covered is insured by the DENTENZA[®] Commercial Coverage Program and that the information provided is to the best of my/our knowledge, complete and accurate. I/We authorize to DENTENZA[®] representatives and agents contacting and obtaining information from the patient, the patient's family, and the facility acting on behalf of the patient. Payment may be made only after the DENTENZA[®] program administrator is given any time without notice. Once payment is received, I/agent agrees to any pay-to-invoice submission for my patient to the DENTENZA[®] program administrator.

Name

Title

Date

Signature

Name

Title

Date

Signature


If all information is provided and there is no missing information, you should receive payment on behalf of your patient for any outstanding claim balances for DENTENZA[®]. There is any missing information, the payment will not be processed and the information is received, no reimbursement will be provided.

Please fax completed and signed form to 1-855-516-7564. For any questions, please call 1-800-239-8346 Option 4.

DISCLAIMER:

DENTENZA[®] Patient Support services are subject to change without notice. For DENTENZA[®] Commercial Coverage Program and Patient Support services, please refer to the DENTENZA[®] Commercial Coverage Program and Patient Support Manual for more information. Many information or factors to submit and required documentation is a primary reason may result in patient disqualification from the DENTENZA[®] Commercial Coverage Program.

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- 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.



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
UTILIZED FOR DAMAGED OR UNUSABLE PRODUCT

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

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

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

DEXTENZA Replacement Process:

- VISIT** us at www.DEXTENZA.com or **CONTACT** DEXTENZA360 at 1-800-339-8369 to request a form.
- COMPLETE, SIGN, and FAX** the Product Replacement Form to 1-855-518-7564.
- 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.
- Once the Product Replacement Form is received and approved, customer should **RECEIVE** your replacement product within 5-10 business days (shipped from Cardinal Health).

REPLACEMENT FORMS
PRODUCT INSERT 1-A PRODUCT INSERT 2-A

Request for Replacement of Unusable Product ELIGIBILITY ATTESTATION FORM
For Use with Product Units 2963

If a DEXTENZA insert is deemed unusable (per the attached statement below), Dextenza Therapeutics may send a replacement product via the DEXTENZA360 program.

- Please complete this form in its entirety and fax to: DEXTENZA360 at 1-855-518-7564.
- The physician/facility must sign the statement.
- 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 DEXTENZA360 at 1-800-339-8369 Option 4 if you have any questions or need additional information on program eligibility.
- Product replacement is subject to Dextenza Therapeutics' policies and procedures regarding product replacement and Dextenza Therapeutics' right, in its sole discretion, to deny replacement when misuse is suspected.

Today's Date: _____ **Date of Incident:** _____

Inserting Provider Name: _____ **Signing Provider Name:** _____
Inserting Provider Identifier (NPI): _____ **Signing Provider Identifier (NPI):** _____
Facility Name: _____ **Facility City:** _____ **Facility State:** _____ **Zip Code:** _____
Facility Address: _____ **Facility Phone Number:** _____
Contact Name: _____ **Contact Email:** _____
Contact Phone: _____ **Contact Fax:** _____

***Attestation Statement:** _____ (Signing Provider Name)

Request for Replacement of Unusable Product ELIGIBILITY ATTESTATION FORM
For Use with Product Units 2963

If a DEXTENZA insert is deemed unusable (per the attached statement below), Dextenza Therapeutics may send a replacement product via the DEXTENZA360 program.

- Please complete this form in its entirety and fax to: DEXTENZA360 at 1-855-518-7564.
- The physician/facility must sign the statement.
- 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 DEXTENZA360 at 1-800-339-8369 Option 4 if you have any questions or need additional information on program eligibility.
- Product replacement is subject to Dextenza Therapeutics' policies and procedures regarding product replacement and Dextenza Therapeutics' right, in its sole discretion, to deny replacement when misuse is suspected.

Today's Date: _____ **Date of Incident:** _____

Inserting Provider Name: _____ **Signing Provider Name:** _____
Inserting Provider Identifier (NPI): _____ **Signing Provider Identifier (NPI):** _____
Facility Name: _____ **Facility City:** _____ **Facility State:** _____ **Zip Code:** _____
Facility Address: _____ **Facility Phone Number:** _____
Contact Name: _____ **Contact Email:** _____
Contact Phone: _____ **Contact Fax:** _____

***Attestation Statement:** _____ (Signing Provider Name)

I hereby attest that DEXTENZA is not usable due to reason(s) below for the quantity listed (total quantity should not exceed 5):

☐ Repetition before subject insertion (swelling)

☐ Mishandling or dropping

☐ Pinch being mishandled or squeezed

☐ Temperature not being maintained at 2-8°C (36-67°F)

☐ Missing product in the pouch

☐ Other (Please provide explanation/description below): _____

DEXTENZA Product Information: _____ **Total Unusable Units:** _____

Lot # _____ **Lot #** _____ **Lot #** _____

Additionally, I attest that this product was purchased for an FDA-approved indication, was never administered to a patient, and furthermore, no return request will be sought for the damaged product or use of the damaged product.

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

By signing this form, I attest that this information is true, accurate and complete to the best of my knowledge.

Provider Signature: _____ (Signature that is legible and matches the name on the form)

For an attestation statement to be valid and product to be replaced, the signature of the ordering/performing provider is required. In the event of a multi-unit loss, please contact DEXTENZA360 for further instructions.

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(dexamethasone ophthalmic insert) 0.4 mg
for intracanalicular use

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DEXTENZA360 is a trademark of Dextenza Therapeutics, Inc.

Dextenza360®
Next business day replacement service

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**
- 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.

REPLACEMENT FORMS

The image shows two versions of the 'Product Replacement Form' side-by-side. Both forms are titled 'Product Replacement Form' and 'ELIGIBILITY ATTESTATION FORM'. The left form is for 'PRODUCT UNITS 1-5' and the right form is for 'PRODUCT UNITS 6+'. Both forms contain fields for patient information, physician information, and a section for 'Description of Incident'.

PRODUCT UNITS 1-5 PRODUCT UNITS 6+

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



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

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.

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#: _____
 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 provider, 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

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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.

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: _____

1 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 <input type="checkbox"/> OD <input type="checkbox"/>
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 - J-Code 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.

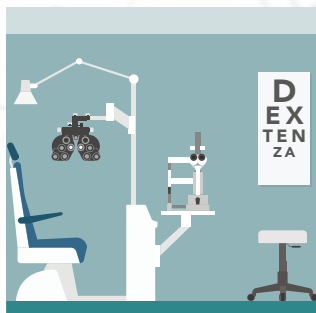
** Reimbursement amount will be determined by provider/facility specific contract with the insurance carrier.

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

Page 1 of 2

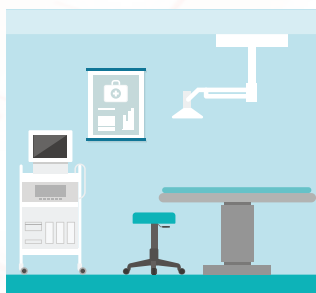
NOTE: The Benefits Summary Form is not a guarantee of insurance coverage. All benefits are subject to the insured's plan at the time services are rendered. Under no circumstances shall DEXTENZA360 be held responsible or liable for payment of any claims, benefits, or costs.

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).

HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>	
1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (VSP) <input type="checkbox"/> FECA (BULKING ROW) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>		2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, John A.		3. PATIENT'S BIRTH DATE MM DD YY 01 02 22		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 123 45 6789A		5. INSURED'S DATE OF BIRTH MM DD YY 01 02 22		6. INSURED'S SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
7. PATIENT'S ADDRESS (No. Street) 123 Main Street		8. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		9. RESERVED FOR NUCC USE		10. INSURED'S ADDRESS (No. Street)		11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH MM DD YY 01 02 22	
13. CITY Anytown		14. STATE MA		15. ZIP CODE 12345		16. TELEPHONE (Include Area Code) (555) 555-5555		17. ZIP CODE ()		18. TELEPHONE (Include Area Code) ()	
19. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		20. IS PATIENT'S CONDITION RELATED TO:		21. INSURED'S POLICY GROUP OR FECA NUMBER		22. INSURED'S DATE OF BIRTH MM DD YY 01 02 22		23. INSURED'S SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		24. OTHER CLAIM ID (Designated by NUCC)	
25. OTHER INSURED'S POLICY OR GROUP NUMBER		26. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>		27. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. PLACE (State) MA		29. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		30. INSURANCE PLAN NAME OR PROGRAM NAME	
31. RESERVED FOR NUCC USE		32. CLAIM CODES (Designated by NUCC)		33. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		34. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		35. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		36. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
37. READ BACK OF FORM BEFORE COMPLETION & 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.											
38. SIGNED _____ DATE _____				39. SIGNED _____ DATE _____				40. SIGNED _____ DATE _____			
41. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 01 02 22				42. OTHER DATE MM DD YY 01 02 22				43. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 01 02 22			
44. NAME OF REFERRING PROVIDER OR OTHER SOURCE 123456789				45. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 01 02 22				46. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES			
47. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				48. RESUBMISSION CODE				49. ORIGINAL REF. NO.			
50. PRIOR AUTHORIZATION NUMBER				51. PRIOR AUTHORIZATION NUMBER				52. PRIOR AUTHORIZATION NUMBER			
53. PATIENT'S OR NATURE OF ILLNESS OR INJURY (Refer to service line below (24E)) A. XXX "X" B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				54. ICD 10 0				55. ICD 10 0			
56. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				57. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				58. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
59. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				60. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				61. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
62. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				63. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				64. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
65. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				66. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				67. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
68. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				69. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				70. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
71. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				72. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				73. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
74. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				75. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				76. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
77. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				78. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				79. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
80. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				81. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				82. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
83. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				84. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				85. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
86. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				87. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				88. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
89. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				90. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				91. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
92. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				93. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				94. A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			

*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 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.

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

1. MEDICARE ☒ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA (EMPLOYER) ☐ OTHER ☐ 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) **MM/DD/YY** SEX **M** 4. INSURED'S NAME (Last Name, First Name, Middle Initial) **Smith, John A.**

5. PATIENT'S ADDRESS (No., Street) **123 Main Street** 6. PATIENT RELATIONSHIP TO INSURED **Self** 7. INSURED'S ADDRESS (No., Street) **123 Main Street**

CITY **Anytown** STATE **MA** 8. RESERVED FOR NUCC USE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? d. INSURANCE PLAN NAME OR PROGRAM NAME

11. INSURED'S POLICY GROUP OR FECA NUMBER 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.) 13. INSURED'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.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? 21. DISORDER OR NATURE OF ILLNESS OR INJURY (Relate to service line below (24E)) ICD-10 **010122** 22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO B. FISCAL YEAR C. PROCEDURE, SERVICE, OR SUPPLY (Eight Unusual Circumstances) D. DIAGNOSIS POINTER E. CHARGES F. AMOUNT PAID G. AMOUNT PAID H. AMOUNT PAID I. AMOUNT PAID J. AMOUNT PAID

1 **01 01 22 01 01 22 11** **68841** **A** **XXX XX 2** **NP1** **1234567890**

2 **N470382020401 UN1** **J1096** **A** **XXX XX 8** **NP1** **1234567890**

3 **01 01 22 01 01 22 11** **J1096** **A** **XXX XX 8** **NP1** **1234567890**

4 **01 01 22 01 01 22 11** **J1096** **A** **XXX XX 8** **NP1** **1234567890**

5 **01 01 22 01 01 22 11** **J1096** **A** **XXX XX 8** **NP1** **1234567890**

6 **01 01 22 01 01 22 11** **J1096** **A** **XXX XX 8** **NP1** **1234567890**

25. FEDERAL TAX I.D. NUMBER **01-0122** 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? **YES** 28. TOTAL CHARGE **\$123.45** 29. AMOUNT PAID **\$0.00** 30. Resv for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (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 **NP1** DATE **01/01/22** NPUCC 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 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

1. MEDICARE ☒ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ OTHER ☐ (If other, specify) ☐ (ID#)

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

3. PATIENT'S BIRTH DATE (MM/DD/YY)
 MM/DD/YY

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 123 45 6789A

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

6. PATIENT RELATIONSHIP TO INSURED
 Self ☒ Spouse ☐ Child ☐ Other ☐

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

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 a. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐
 b. AUTO ACCIDENT? YES ☐ NO ☐
 c. OTHER ACCIDENT? YES ☐ NO ☐
 d. INSURANCE PLAN NAME OR PROGRAM NAME

11. INSURED'S POLICY GROUP OR FECA NUMBER
 b. INSURED'S DATE OF BIRTH (MM/DD/YY) MM/DD/YY
 c. OTHER CLAIM ID (Designated by NUCC)
 d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, complete items 9, 9a, and 9d.

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
 FROM MM/DD/YY TO MM/DD/YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
 NAME 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 (Relate to service line below (24E)) ICD-10 ☐ 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 EMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. UNIT OR LINES H. ID. QUAL I. 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

4

5

6

25. FEDERAL TAX I.D. NUMBER SSN EIN ☒ 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (If yes, check box) YES ☒ NO ☐ 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rev'd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (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
 NPI

33. BILLING PROVIDER INFO & PH # (123) 456-7890
 Any ASC
 123 Anystreet
 Anytown, MA 12345
 NPI

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).

†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.

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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

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

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

3. PATIENT'S BIRTH DATE (MM/DD/YY)
MM/DD/YY

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
123 45 6789A

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 Main Street

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐
 b. AUTO ACCIDENT? YES ☐ NO ☐
 c. OTHER ACCIDENT? YES ☐ NO ☐
 d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

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: _____ DATE: _____

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
 NAME
 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. DISORDER OR NATURE OF ILLNESS OR INJURY (Relate to service line below (24E)) ICD-10 Code: **0**

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. FOCUS OF SERVICE EMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS D. DIAGNOSIS POINT E. CHARGES F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MM. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.

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. Rev'd 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.))

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # (123) 456-7890
 Any ASC
 123 Anystreet
 Anytown, MA 12345

SIGNED: _____ DATE: _____

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.

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Facility CMS-1450 Claim form for DEXTENZA Insertion in HOPD

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

Enter the procedure code to designate cataract surgery.

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.

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.

Enter the appropriate ICD[†]-10 code(s).

Any Hospital 123 Any Street Any Town, MA 12345		Any Hospital 123 Any Street Any Town, MA 12345		1234 5 FID. TAX NO. _____	
8 PATIENT NAME Doe, John		9 PATIENT ADDRESS 123 Any Street		32 PAY. CTRY. # _____	
10 BIRTHDATE _____		11 SEX _____		12 DATE _____	
13 HR. 14 TYPE 15 SRC 16 DWR _____		17 STAT _____		18 19 20 21 22 23 24 25 26 27 28 29 ACCT 30 _____	
02/21/1954		01		MA # 12345	
31 OCCURRENCE CODE _____		32 OCCURRENCE DATE _____		33 OCCURRENCE CODE _____	
34 OCCURRENCE DATE _____		35 OCCURRENCE CODE _____		36 OCCURRENCE SPAN FROM _____ THROUGH _____	
37 OCCURRENCE DATE _____		38 OCCURRENCE CODE _____		39 OCCURRENCE SPAN FROM _____ THROUGH _____	
40 VALUE CODES AMOUNT _____		41 VALUE CODES AMOUNT _____		42 VALUE CODES AMOUNT _____	
43 VALUE CODES AMOUNT _____		44 VALUE CODES AMOUNT _____		45 VALUE CODES AMOUNT _____	
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148 VALUE CODES AMOUNT _____		149 VALUE CODES AMOUNT _____		150 VALUE CODES AMOUNT _____	
151 VALUE CODES AMOUNT _____		152 VALUE CODES AMOUNT _____		153 VALUE CODES AMOUNT _____	
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163 VALUE CODES AMOUNT _____		164 VALUE CODES AMOUNT _____		165 VALUE CODES AMOUNT _____	
166 VALUE CODES AMOUNT _____		167 VALUE CODES AMOUNT _____		168 VALUE CODES AMOUNT _____	
169 VALUE CODES AMOUNT _____		170 VALUE CODES AMOUNT _____		171 VALUE CODES AMOUNT _____	
172 VALUE CODES AMOUNT _____		1			

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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.



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Dextenza[®] 360[™]

Patient Access and Reimbursement Services

