DEXTENZA® COMMERCIAL ASSURANCE PROGRAM
PATIENT ENROLLMENT FORM

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

The **DEXTENZA® Commercial Assurance Program** is a patient assistance program designed to assist eligible* patients, **who have coverage for DEXTENZA (J1096) through a commercial insurance plan†**. Financial assistance provided by the DEXTENZA Commercial Assurance Program may be applied only towards the cost-sharing amount owed by the patient for his or her DEXTENZA treatment, including applicable co-payments, coinsurance, deductibles, or the amount that results when the allowable is less than the provider's invoice cost.

Along with the signed Patient Enrollment Form, 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. Must be submitted within 180 days of the date of service.
- **Original claim form** (HCFA 1500 or UB-04)
- **Invoice from the DEXTENZA unit** used for the patient which shows the acquisition cost (Must be within 180 days of the date of service)
- **Fax** the signed **Patient Enrollment Form**, along with the **EOB, claim form and invoice** to **855-518-7564**

Once processed and approved, payment is provided to the provider on behalf of the patient via check or electronically (ACH), depending on preference. An explanation of payment will accompany each disbursement.

Patient/Physician Information

Patient Name (First, Middle and Last):

Date of Birth (MM/DD/YY):

Patient Address:

City:

State:

Zip Code:

Physician Name:

Physician National Provider Identifier:

Date of Insertion: (MM/DD/YY)

Office/Facility Information

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

Office/Facility Name:

Office/Facility Phone Number:

Office/Facility Address:

City:

State:

Zip Code:

Office/Facility Email:

Office/Facility Fax Number:

Office/Facility Tax ID:

Office/Facility Certification

I authorize the use or disclosure of the patient's health information contained on this enrollment form to Ocular Therapeutix's DEXTENZA Commercial Assurance Program and Ocular Therapeutix™ to determine the patient's eligibility for the Program. 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), for the purposes permitted under this "Office Certification" Section. I consent to Ocular Therapeutix's representatives and agents contacting me and this facility to request additional information as needed. I, and this facility/office agree that Ocular Therapeutix may change or terminate any of the DEXTENZA Commercial Assurance Program services at any time without notice. I certify 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. Once payment is received, I agree to promptly return any out-of-pocket costs collected from my patient for the DEXTENZA product.

Physician or Office/Facility Administrator 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. If there is any missing information, you will be contacted and no payment will be processed until the information is received.

Please fax completed and signed form and supporting documentation to 855-518-7564.
For any questions, please call 877-286-2207.

DISCLAIMER:
The DEXTENZA Commercial Assurance Program program services are subject to change without notice. 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. Ocular Therapeutix reserves the right to modify or discontinue the DEXTENZA Commercial Assurance Program in part or in its entirety, at any time.

* The DEXTENZA Commercial Assurance Program patient eligibility includes adult and pediatric patients being treated for ocular inflammation and pain following ophthalmic surgery, as well as adult and pediatric patients 2 years of age and older being treated for ocular itching associated with allergic conjunctivitis. The use of DEXTENZA is not recommended for the treatment of ocular itching associated with allergic conjunctivitis in pediatric patients who require sedation for the insertion procedure. This benefit is not available for patients with any government insurance including but not limited to Medicare Part B, Medicare Part C (Medicare Advantage) or Medicare Part D, Medicaid, VA, DoD, TRICARE, CHAMPVA or any other federally or state-funded government-assisted program.

† Up to the provider/facility acquisition cost not to exceed a maximum benefit of the current, published Wholesale Acquisition Cost on the date of service per unit of DEXTENZA. Program applies to the drug only. Commercial Assurance Program claims will apply towards Ocular's Rebate Program tiers; however, a unit will not be eligible for a rebate under Ocular's Rebate Program if the CAP reimbursement equals the acquisition cost.

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

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OcuCare™
PATIENT ACCESS AND REIMBURSEMENT SERVICES