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**

Dextenza360™
Patient Access and Reimbursement Services