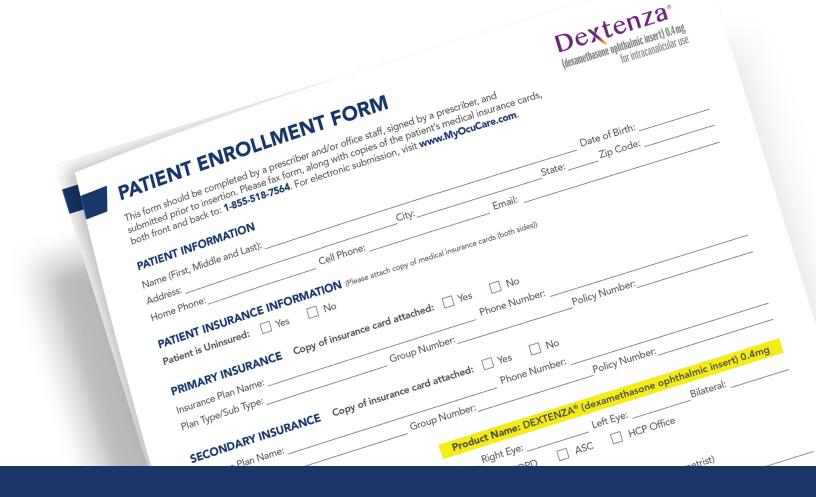


FATIENT ACCESS AND REIMBORSEMENT SERVICES

Reimbursement Guidebook

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



Click, Call, or Connect MyOcuCare.com

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



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

Connect to Us

www.DEXTENZA.com www.MyOcuCare.com



www.twitter.com/OCUTX



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

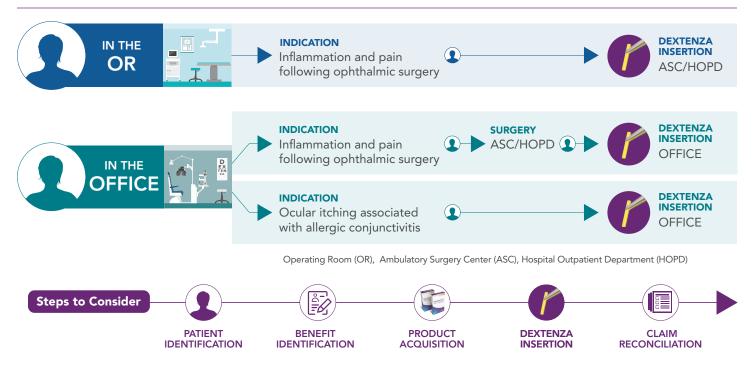
Table of Contents

The Role of OcuCare In Patient Access to DEXTENZA	4
DEXTENZA Patient Journey	4
Your Dedicated DEXTENZA Team	4
Reimbursement Roadmap	5
How to Order DEXTENZA	6
Storage and Handling	6
Billing Codes for DEXTENZA	7
Product and Procedure Billing Codes	7
ICD-10 Codes	8
Possible Applicable Modifiers	9
Available Patient and Product Programs	10
Patient Assistance Program (PAP) Application Information	11
Commercial Assurance Program (CAP) Overview and Criteria	12
Product Replacement Program Overview and Criteria	13
OcuCare Overview	14
OcuCare Portal	15
OcuCare Patient Enrollment Form	16
Benefits Identification Form	17
CMS Forms	18
Important Safety Information	24

Click on page number to jump to page.

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

DEXTENZA Patient Journey



Your Dedicated DEXTENZA Team

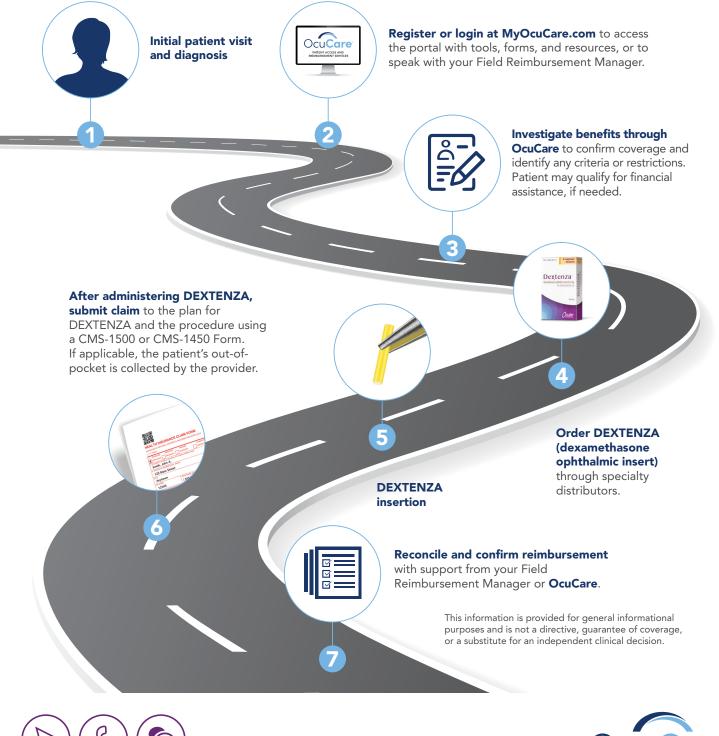


Your dedicated DEXTENZA team consists of a national account director, key account manager, medical director, OcuCare case manager, and field reimbursement manager. Our Medical Affairs team is also available to assist with any questions.



Reimbursement Roadmap

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



Click, Call, or Connect MyOcuCare.com



How to Order DEXTENZA

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

DISTRIBUTOR	PHONE	FAX	WEBSITE
Besse Medical	1-800-543-2111	1-800-543-8695	www.besse.com
Cardinal Specialty Pharma Distribution	1-855-855-0708	1-614-553-6301	www.cardinalhealth.com/specialtyonline
FFF Enterprises	1-800-843-7477	1-800-418-4333	biosupply.fffenterprises.com
Henry Schein	1-800-722-4346	1-800-329-9109	www.henryschein.com/medical
Metro Medical	1-800-768-2002	1-615-256-4194	www.metromedicalorder.com
McKesson Medical-Surgical	1-855-571-2100	1-800-311-3408	mms.mckesson.com
McKesson Plasma & 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.





Product and Procedure Billing Codes

Product Reimbursement

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

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

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

Procedure Reimbursement

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

* Medicare Advantage (Part C) and Commercial plans may or may not follow Medicare recommendations in making coverage decisions. Payment rates may vary per facility contracts.

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

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

[§] CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT), an alphanumeric coding system maintained by the American Medical Association to identify medical services and procedures provided by physicians and other healthcare professionals.



ICD-10 Codes

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

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

ICD*-10 Codes Associated with Ophthalmic Surgery

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

ICD-10 Codes Associated with Allergic Conjunctivitis

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

*International Classifications of Diseases (ICD).



TIP TO REMEMBER

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

Find more information about HCPCS codes at https://www.cms.gov/medicare/coding/medhcpcsgeninfo



Possible Applicable Modifiers

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

This may not be a complete list of modifiers. Visit **https://www.cms.gov/Medicare/Coding/ HCPCSReleaseCodeSets/HCPCS-Quarterly-Update** for a complete list of modifiers.

Possible Applicable Modifiers

Description	Modifier
Left side (used to identify procedures performed on the left side of the body)	LT
Right side (used to identify procedures performed on the right side of the body)	RT
Upper left, eyelid	E1
Lower left, eyelid	E2
Upper right, eyelid	E3
Lower right, eyelid	E4
Staged or Related Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period	58
Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Healthcare Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	78
Unrelated Procedure by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period	79



TIP TO REMEMBER

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

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



AVAILABLE PATIENT AND PRODUCT PROGRAMS

Complete Review and complete entire form	r at www.MyOcuCare.com.	Fax to OcuCare a
Inter Name/East Middle and Last	•	VMDD/YY: Patent Phone Number:
late of Insetion (MM/DD/YY) Patient Address:	City.	State: Zp Code: 0
unant Maderations		
Lineit Medications	Drug Allergies	1
Prescription (Rx) and Prescriber Attestat		
roduct Name: DEXTENZA® (dexamethasone ophthal	inic insert) 0.4 mg	
Directions for Use:		
Duantity. DAW. Substitution All	laved: Reflix	
hesoriber Name (Print):	Prescriber Signature:	Dute (MM/DD/111)
hesz/ber Address:	National Provider Identifier Standa	nd (NPI): Prescriber Phane Na
Prescriber Attestation: By signing this form. I get By that the p	second as which from its proceeding when inform	the second state of the second s
If the surgery/procedure is rescheduled for a later date, I street admonithing that CEXTINDA will not be offend for alls, and appen Lunderstand that COURTINDA will not be right to concern my satis- igning this form, I am Scenard to practice at the requested why ryou are a preaches in Adhama, Indiana, Konas, Mississippi, the official prescription form with this application.	I no claim for reimbursement of the DEXTENZA pri- ent to arrange shipment of DEXTENZA, and to mo preent location.	oduct will be submitted to Medicare, Medicaid, or any third- odily or discontinue the program at any time. I confirm that b
tate official prescription torin with the approachon.		
Patient Authorization to Use/Disclose H/ iyingh sinu, Isani anto Buki for Buki Shari (Bokuri yi Talcara) a bahi for Coular indexed in the Collaro NP Talcara (Bokuri Charanda) and the Shari (Bokuri NP Talcara) and the Shari (Coular Shari) and the Shari (Shari (Shari) and the Shari (Shari) and the Shari (Shari (Shari) and the Shari (Shari) and antonionishi (Shari (Shari) and the Shari (Shari) and antonionishi (Shari (Shari) and the Shari antonionishi (Shari (Shari) and the Shari (Shari) and antonionishi (Shari (Shari) and the Shari antonionishi (Shari (Shari) and the Shari (Shari) Shari (Shari (Shari) antonionishi (Shari) Shari (Shari (Shari) antonionishi (Shari) Shari (Sh	and its representatives, append, and contraction (), use and shave anong thereasives any personal hit the Couches Patient Assistance Program (the exactions, assistance services) (understand that or a disclosed to outher. I also understand that the shart may which may contain information act only and the shart may contain information act only pages any conditioners, the Couche spectra may condition request, the Couche spect only condition.	Auffing the OanCare Parisent Auditance Program open auth information and an antibiation of the pariset of the programmed (2) understating frameal support services, include discussion, supplies, or maintees by OanCare Parisets, include discussion, and the authors are discussed and the OanCares Patients and with certain. Distributes as destructed also Douclears Patients and the attention and the Eritchics in the authors and the attention of the patients and inclusion. In the authors are apprecised and the termina- tion of the attention of the attention of the attention are imports for proposed of dissembling investigation for the name of the patients. Authors are apprecised on the three name of the attention of t
understand that I may refuse to sign this authorization and it receiving in the DocLare Patient Audstance Program . Take Data Therapsector, loc., 24 Consulty Drive, Bedderd, MA O 541 by Entries before they actually movies notice of my cance enion. I understand that Takwa e right to receive a copy of the form my health plan (F applicable).	understand that I may cancel this authorization a 1720 and requesting such cancellation, but that a sellation. If I do not cancel this authorization earlier	It any time by writing to OcuCare Patient Assistance Pro any such cancellation will not affect the sharing and use of scit will remain valid for 50 years from the date of my sion
atient or Representative Name (Print):	Patient or Representative Signature	e: Dute (MM/DD/Y
Initiationship to Patient (If signed by a representative)		

PATIENT ASSISTANCE PROGRAM (PAP)



COMMERCIAL ASSURANCE PROGRAM (CAP)



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

PRODUCT REPLACEMENT PROGRAM



Click, Call, or Connect MyOcuCare.com



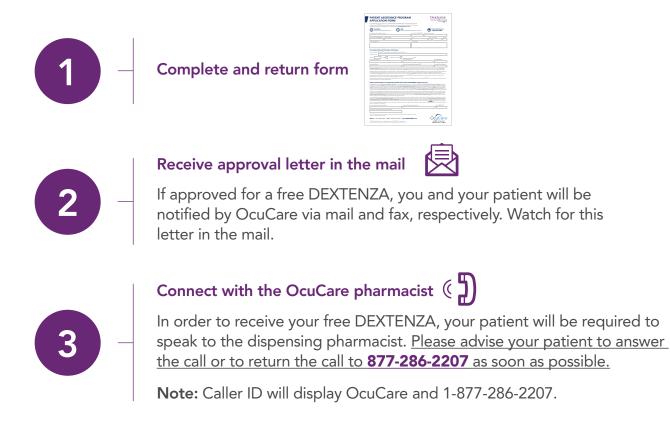
Patient Assistance Program (PAP) Application Information

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

To be eligible, a patient must be a U.S. resident, and have an annual income <500% of the Federal Poverty Level (FPL), adjusted for family size.



The following steps are required for your free DEXTENZA to arrive in time for your procedure.



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

NOTE: Please advise your patient to inform their health plan (if applicable) that you have received DEXTENZA free of charge.

Ocular Therapeutix reserves the right to modify or discontinue the DEXTENZA Patient Assistance Program in part or in its entirety, at any time. Free product is contingent upon program eligibility requirements.



Commercial Assurance Program (CAP) Overview and Criteria

	© COMMERCIAL E PROGRAM	Dextenza (Issuedraw with the tard Using to reaconfide at
have coverage for DI DEXTENZA Commerce his or her DEXTENZA when the allowable is	mercial Assurance Program is a patient assistance pro EXTERZA (199%) through a commercial Insurance al Assurance Program may be applied only towards to treatment, inducting applicable or commente, colresur less than the provider's invoice cost. ility Requirements, Terms and Conc	plan". Financial assistance provided by the be cost-sharing amount owed by the patient for ance, deductibles, or the amount that results
	Patient must not have government insurance including but not instead to, but not instead to, but not instead to a second second field cases of the second second second national program. DEXTENZA must be converted by the patient conversed or prohese insurance. If coverage is desired, patient will not be eligible for the program.	 Patient must be 18 years or older. Offer only wild in the US and its territoris; voldwhee prohibited by law, tasked or restricted.
How To Enroll	A Patient Along with the signed Patient Enrolment Flo- c Case, legible, and iterated Englaneties of Banefits (EOB) showing the data of savies, bit covered arrows for DEXENDA, and any patient out-of-podet maponability. Must be submitted within 180 days of the date of savies. • Original datas from (PICA 1500 or UB-04)	m, the following are required: Invoice from the DEXTENCA unit und for the patient which shows the acquisition core (Must be within 180 days of the date of service) Fact the algore Petient Korollinent Form, along with the EOS, claim form and invoice to 1435 518 7544
electronically (ACH), o	pproved, pyment is provided to the provider on be spending on preference. An explanation of payment sestions? Contact the DEXTENZA Comme 877-286-2207 Monday - Friday 8:00AM	vill accompany each disburiement. rolal Assurance Program
Internations of Inflation in solution or alternatives the IEEE/INEA "The DERTINIA Conversation, including had seen limited to As "Up to the provided fielding an Program datase all apply tase Relative Programs of the CAP or Phone: 1–8777–2886-229 Q 2223 Coulor Thromatics Int County Phone: 1–8777–2886-229	neurona Payman pagnan semistra na kalpin ta Angu sellika sening Anna and angula disambatikan kalpin semistra ong senih selika mangula disambat disambatikan paya selika selika disambat manguna disambat disa	ni dagadilarine. Dedar Theoremain warnes for right to multy envent i havenes medid bescence andere unite Dedar

PATIENT ENROLLMENT FORM			(dexamediazane ophiladaric incert) 64 m hr intercondicular no
The DEXTENZA [®] Commercial Assurance Program is a for DEXTENZA (11696) through a commercial insuran Program may be applied only towards the cost-sharing a co-payments, colinaurance, deductibles, or the amount the	sce plan ⁷ . Fin amount ower	ancial assistance provided by the 0 I by the patient for his or her DEXT	DEXTENZA Commercial Assurance IENZA treatment, including applicab
Along with the signed Patient of the signed Patient of the following are required: Fax	service, the c ponsibility. M sginal claim f voice from th quisition cost x the signed i d invoice to i o the provide		d any patient out-of-pocket of the date of service. Intert which shows the as of service) ich the ECB, dates form
Patient/Physician Information			
Patient Name (Fini, Miside and Lea)		Date of Birth (MEDD/VV)	
Patient Asidews	_	Oly	State ZpCode
Physician Nama		Physiciae National Provider Identifies	Date of Insertion (MICOD/Y)
Office/Pacity Address Office/Pacity Ereck	_	Oly Dise?telly?telly?teller	Date: ZpCole Disc Pacity Sec D.
Office/Facility Certification Industry for an or shallower of the patient's health information run and Churd Theoremics the strategies of the strategies of the patient's personally identifiable health information (including diagnosis, testions, I consent in Churd Theoremich, increasing diagnosis, testions, I consent in Churd Theoremich, and and the Statistican of agents that Chular Theoremica age abart of the Statistican and agents index in any automation or a patient of the Statistican and the the the	ogram. I santify i socialization and socializing meria 23. Communial J menuism anodal	had 1 have addational my patient's authorized instance information), for the purposes po of this facility to request additional informa- lancement Program services at any time atom of is, to the lawsi of no instances, consult	en as required by HEAA to use and shadow weited under UAs "Dilate Certification" for as resoluted, and this facility/office agree not realized. I settly that the solitient spread
agues la primpily relari ery sol of public units sollasted from my pa Physician or Office Pacifity Idenivisitation Taylories Nerves Uppelves Taylories			
agene in promptly triters are a sol of pushet scale collected from my pa Psychiae or Ollina Paully Interivitation Topology Nerve.			
agent to promptly related any solid of possist costs collected from my path Physician or Office/Paulity Administrative Signationy Names	hauld reserve po	prearest are lashalf of your patients. If there is,	ary relating information, you will be
agen to propring in status any solid pandat assoli salibated from one yoo Physician or Olifon Tanlity Administrator Eigenstray Teires. Eigensees If all administration is provided and there have associated administration, you ob administration of our propriet with the presence of the formation or one Physician Completion of and adgreed Terms and our Physician Completion of and adgreed Terms and our Physician Completion of and adgreed Terms and our Physician Operational (1977-288-22027)	mailand.		my vising information, you will be
Agent to perspective of the second se	extent apporting de excluses to observe to its in antiset	ocumentation to 855-518-7564. ge utilized rotate. Onder Theoperate de roug routility patient disquidilation. On g dory line.	n ni maratise nivîaraswanî. Minine
age to sense the standard balance in the sense of the sense of the sense of the sense of the sense is the sense of the se	entions apporting di entiopert to observe a tori in its antioni ent available for age (Mediane In)	accumentation to 855-518-7564. up atheat value. Only Theopenis de may weak in patient should attent. On a any mea. printe Atheat parameters in success splanment plan.	es sei guarantee reinduraamani. Maaing dar Theogendia maaruus ike right ia madij
experts to provide structure to and a limit of the many particular or think and the main particular or think and the structure to provide the structure of the	nation! apporting di a silonely more a timely more up Menican fit para applies to t para applies to t	commentation to 855-518-7564.	es sei guarantee reinduraamani. Maaing dar Theogendia maaruus ike right ia madij

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.

Program Eligibility Requirements

- Patient must not have government insurance including, but not limited to, Medicare, Medicaid, Medicare Advantage (Medicare Replacement) or any other federally or state-funded government-assisted program.
- DEXTENZA must be covered by the patient's commercial or private insurance. If coverage is denied, patient will not be eligible for the program.
- Patient must be 18 years or older.
- Offer only valid in the US and its territories; void where prohibited by law, taxed or restricted.

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 ٠ invoice to 1-855-518-7564

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.

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 benefit is not available for patients with any government insurance including but not limited to Medicare, Medicaid, Medicare Advantage (Medicare Replacement) plans
- ⁺ Up to the provider/facility acquisition cost (not to exceed \$605). 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.



Product Replacement Program Overview and Criteria

If a DEXTENZA[®] insert is deemed unusable, Ocular Therapeutix may send a replacement product via the OcuCare[™] program.

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

DEXTENZA Replacement Process:

VISIT www.DEXTENZA.com or www.MyOcuCare.com or PHONE 877-286-2207 to request a form.



COMPLETE, SIGN, and **FAX** the **Product Replacement Form** to **1-855-518-7564** or upload via the OcuCare HCP portal at **www.MyOcuCare.com**.



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.

REPL	ACE	MEN	T FC	ORM





Once the Product Replacement Form is received and approved, customer should **RECEIVE** replacement product within 5-10 business days, shipped from Cardinal Health.

PLEASE NOTE:

- The physician or provider must attest that the information provided is true, accurate and complete to the best of his/ her knowledge.
- Product replacement is subject to adherence to Ocular Therapeutix policies and procedures and Ocular Therapeutix has the right, in its sole discretion, to deny replacement when misuse is suspected.

Product is deemed unusable if:

- The product was mishandled, dropped, or broken;
- The product was inappropriately stored, refrigerated, or frozen;
- The product is deemed not appropriate for administration before, during, or after the procedure.



Click, Call, or Connect MyOcuCare.com



Comprehensive Support With OcuCare

YOU AND YOUR PATIENTS - AT THE CENTER OF OUR OCUCARE COMMITMENT

Benefits investigation



Claims assistance

2 business days.

Helping address your questions up front. Receive coding and billing guidance before a claim is submitted, claims assistance and support.



Prior authorization (PA) assistance

A full report, including insurance coverage, within

If a PA is necessary, we provide access to helpful forms and assistance with payer requirements to facilitate approval.



Appeal assistance

Individualized guidance on appeal submission and assistance with documentation and forms. We track the status of appeals and provide updates on the appeals process.



Patient financial assistance programs

Assistance for all qualifying patients. OcuCare will help determine patient eligibility and investigate options.

MAKING OCUCARE SUPPORT CONVENIENT FOR YOU







MyOcuCare.com Portal

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

All Programs are Available on the Portal

- Benefit Investigation Requests
- Commercial Assurance Program Enrollment Enrollment
- DEXTENZA Patient Assistance Program Enrollment
- Unusable Product Replacement Program Requests

New Functionality

- Enhanced Search Capabilities
- Reports
- Upload Documents
 - Insurance Cards
 - Unusable Product Replacement Program Forms
 - DEXTENZA Patient Assistance Program Applications
 - CAP Enrollments

	•
	Create Account Resources Contact Us
	\frown
	OcuCare
	PATIENT ACCESS AND REIMBURSEMENT SERVICES
	<u>USER LOGIN</u>
	Lusername
	A Password
	LOGIN
	Forgot Password
Ocular Therapeutix, Inc. • 24 Crosby Drive • Bedford, MA • 01730 PRIVACY POLICY TERMS OF USE	
	registered trademark, and OcuCare is a trademark of Ocular Therapeutix, Inc. MA-US-DX-0133 notice modify and/or discontinue operation of all or portions of this Site at any time at its sole discretion, and assumes no responsibility to update this Site.



OcuCare Patient Enrollment Form

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

Important Reminders

- Prescriber must sign
- Please send to OcuCare five (5) business days prior to insertion
- Can be faxed or sent electronically through the MyOcuCare.com portal*.

Provide patient and insurance information ———	PATIENT ENROLLMENT FORM Submitted port on insertion Plasse fact for complete day a prescriber and/or office staff, signed by a prescriber, and submitted port on insertion Plasse fact for complete day a prescriber of the patient's medical insurance cards, both front and back to: 1-855-518-7564. For electronic submission, visit www.MyOcuCare.com. PATIENT INFORMATION Mame (First, Middle and Last): City: State: Zip Code: Home Phone: Cell Phone
	Patient INSURANCE INFORMATION (Please attach copy of medical insurance cards (both sidest) 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: Plan Type/Sub Type: Group Number:Policy Number: Plan Type/Sub Type: Group Number:Policy 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:
Complete treatment information section	TREATMENT INFORMATION Preduct 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 MD DO (Osteopath) OD (Optometrist) Prescriber Name:
Complete prescriber and site of insertion information	Office Address (not PO Box):
Prescriber must authorize and confirm the	Per

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

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



Benefits Identification Form

The **OcuCare Benefits Investigation Form** provides the information you need returned via fax or available in the MyOcuCare.com portal (if registered). Comprehensive and convenient, receive results within 48 hours or less.

1	OcuCare Case ID: Refer to this number when speaking to your OcuCare Case Manager	BENEFITS INVESTIGATION FORM	Dextenza (decamethasone ophthalmic insert) 0.4 mg for infractualicial ruse Date Faxed:
	Primary Medical: OcuCare will verify patient's	PATIENT INFORMATION	
2	primary insurance coverage	Patient Name (First, Middle and Last). Date of Birth: Date Verified: Date of Insertion: To (Office Contact). Prescribing Physician ASC/HOPD/Office Name:	:
3	Secondary Medical: OcuCare will verify patient's secondary insurance coverage	PATIENT INSURANCE 2 PRIMARY MEDICAL Payer Name: Payer Name: Insurance Type: Insurance Type: Payer Name: Payer Name	3
4	DEXTENZA Billing Code: Provides suggested billing guidelines for the DEXTENZA product HCPCS J-code and CPT Code (physician/facility fee)	Payer Type: Poler Type: Effective Date: Poler Type: Group Number: Effective Date: Policy Number: Group Number: Policy Number: Policy Number:	for DEXTENZA Insertion.
5	DEXTENZA Cost Share: Indicates patient's financial responsibility for the product	Paver Name Coverage	t of Pocket Out of Pocket Prior Auth. Amount Met Prior Auth.
6	Prior Authorization Required: Indicates if the patient's plan requires a prior authorization for DEXTENZA	ADDITIONAL INFORMATION	
7	Secondary Insurance: Patient's payer specific coverage information and suggested codes	This is not a guarantee of insurance coverage or payment. All benefits are subject to the insured's rendered. Under no circumstances shall the QcuCare Patient Access and Reimbursement Services be held reponsible or table for payment of any claims, benefits or cost. Any coding information provided for informational purposes only, is subject to change, and should not be construed as le independent clinical judgment when selecting codes and submitting claims to accurately reflect the to the specific patient. Phone: 1-877-286-2207 Fax: 1-855-518-7564 www.DEXTENZA.com © 2023 Ocular Therapeuts, loc. All rights reserved. DEXTENZA is a registered tademant and OcuCare is a trademark of Ocular Therapeutic, loc. MAUSDX0120	program nor Ocular Therapeutix discussed in this document is gal advice. Providers should exercise

NOTE: The Benefits Investigation Form is not a guarantee of insurance coverage or payment. All benefits are subject to the insured's plan at the time services are rendered. Under no circumstances shall the OcuCare Patient Access and Reimbursement Services program nor Ocular Therapeutix be held responsible or liable for payment of any claims, benefits or cost. Any coding information discussed in this document is provided for informational purposes only, is subject to change, and should not be construed as legal advice. Providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to the specific patient.





Sample CMS Forms for DEXTENZA



IN THE OFFICE

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

_				
	Ô	/		
	-	_	_	
	T			

IN THE OPERATING ROOM ASC/HOPD

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



Click, Call, or Connect MyOcuCare.com



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

Box 21	_											
Enter the appropriate ICD*-10 code(s).		回读记 回读记 HEALTH INSUR/										
Box 21		APPROVED BY NATIONAL UN	IFORM CLAIM COMMIT	TEE (NUCC) 02/12								
Enter "0" for ICD-10-CM.		1. MEDICARE MEDICAID TRICARE CHAMPVA GBOUP FECA OTHER 1s. INSURED'S LD. NUMBER (For Program in Item 1) Medicaid(9) (Medicaid(9) (0.000009) (Montov 109) (0.00) (0.00) (0.00) 123 45 6789A										
		2. PATIENT'S NAME (Last Name Smith, John A.		itial)	3. PATIENT'S BI	мХ					First Name, N	tiddle Initial)
Dev. 24D		5. PATIENT'S ADDRESS (No. 123 Main Street			Self X Spo	ATIONSHIP TO INS		7. INSURED	D'S ADDRES	iS (No., Sti	reet)	
Box 24B		спу Anytown		STATE MA	8. RESERVED F	OR NUCC USE		CITY				STATE
Enter "24" for ASC.		ZIP CODE 12345	TELEPHONE (Incluse (555) 555					ZIP CODE			TELEPHONE	(Include Area Code)
		9. OTHER INSURED'S NAME	(Last Name, First Name,	Middle Initial)	10. IS PATIENTS	S CONDITION RELA	TED TO:	11. INSURE	D'S POLICY	GROUP	OR FECA NU	IBER
Box 24A		a. OTHER INSURED'S POLIC				T? (Current or Previ	ous)	a. INSUREL M	DIS DATE OF	F BIRTH YY	м	SEX F
Enter N4 qualifier and 11-digit NDC		b. RESERVED FOR NUCC US	E		b, AUTO ACCID		PLACE (State)	b. OTHER (CLAIM ID (D	esignated I	by NUCC)	
code: N470382020401 UN1. [†]		c, RESERVED FOR NUCC US	E		C. OTHER ACCI	DENT? YES NO		C. INSURAN	NCE PLAN N	AME OR P	PROGRAM N/	ME
		d. INSURANCE PLAN NAME (DR PROGRAM NAME		10d. GLAIM COE	DES (Designated by	NUCC)		_		BENEFIT PLA yes, complete	N? a items 9, 9a, and 9d.
Box 24D		REA 12: PATIENT'S OR AUTHORIZ to process this claim, I also		URE Tauthorize the	G & SIGNING THIS release of any med	FORM. Ical or other informatioarty who accepts as	on necessary signment	payment	D'S OR AUT	penefits to	PERSON'S S the undersign	SIGNATURE I authorize ed physician or supplier for
		SIGNED			DATE			SIGNE	ED			
Enter the CPT [‡] code for the		14. DATE OF CURRENT ILLN	ESS, INJURY, or PREGN	IANCY (LMP) 15 QL	OTHER DATE	MM DD	YY	16. DATES FROM	PATIENT UN	ABLE TO	WORK IN CL TO	RRENT OCCUPATION MM DD YY
surgical procedure (e.g., 66984),		17. NAME OF REFERRING PI	ROVIDER OR OTHER SC	DURCE 17	a. b. NPI			18, HOSPIT FROM	ALIZATION I	DATES RE	ELATED TO C TO	URRENT SERVICES MM DD YY
HCPCS code to represent		19. ADDITIONAL CLAIM INFO	RMATION (Designated b	y NUCC)		1		20. OUTSIC	ES	vo I	\$ CH	ARGES
DEXTENZA (J1096) and the		21. DIAGNOSIS OR NATURE	OF ILLNESS OR INJURY	Relate A-L to ser	vice line below (24E	i) ICD Ind. 0		22. RESUB		_	ORIGINAL RE	F. NO.
relevant modifiers.			F.	G.I		н. Ц		23. PRIOR	AUTHORIZA	TION NUM	IBER	
**Please refer to the possible		24. A DATE(S) OF SERV From MM DD YY MM	T- 010000		EDURES, SERVICE ain Unusual Circum		E. DIAGNOSIS POINTER	F.	ages	G. DAYS E OR E	H. I. PSOT ID. Family OLIAI	J. RENDERING PROVIDER ID. #
applicable modifiers.		1 01 01 22 01		669	34		A		xx		NPI	1234567890
		2 N470382020401 01 01 22 01	UNI	J10			A		xx		NPI	1234567890
		3								Υ.	NPI	
		4									NPI	
Box 24F		5		1							NPI	
Enter price of DEXTENZA		6		1	1 1		1	1			NPI	
from price schedule.		25. FEDERAL TAX I.D. NUMB		26. PATIENT'S	ACCOUNT NO.	27. ACCEPT AS Por govt. class X YES	SIGNMENT?	28. TOTAL S	CHARGE	29. A \$	AMOUNT PAIL	30. Revd for NUCC Use
		31. SIGNATURE OF PHYSICI. INCLUDING DEGREES OF (I certify that the statement	AN OR SUPPLIER R CREDENTIALS	32. SERVICE F.	ACILITY LOCATION			33. BILLING Any	ASC	INFO & P	₩# (12	3) 456-7890
		apply to this bill and are ma	de a part thereof.)					123	Anystre own, M		45	
Box 24G		SIGNED	DATE	a. N			2/05		NPI	b.		197 FORM 1500 (02-12)
Enter a unit of 1 for the procedure code		NUCC Instruction Manu	ai available at: www	v.nucc.org	PLEAS	SE PRINT OR 1	TPE		APPHU	VED UN	no-0936-1	197 FURM 1500 (02-12)
(((OOA) Fatan a with a f 4 family a DEVTENIZA	L											

(66984). Enter a unit of 4 for the DEXTENZA HCPCS code (J1096). The HCPCS descriptor for DEXTENZA is 0.1mg.

*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.







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

Box 21

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

Box 21

Enter "0" for ICD-10-CM.

Box 24B -

Enter operating room place of service, e.g., "24" indicates ASC, "22" indicates HOPD.

Box 24D -

Enter the CPT⁺ code for the surgical procedure (e.g., 66984), the CPT code for DEXTENZA insertion (68841) and the relevant modifiers. ****Please refer** to the possible applicable modifiers.

Box 24G -

Enter a unit of 1 for the procedure codes (66984 and 68841).

	APPROVED BY NATIONAL UNIF	ORM CLAIM COMMITTEE (N									
	PICA		UGC) 02/12								
	1. MEDICARE MEDICAI		CHAMPV	- HEALTH PLAN -	FECA OTHE				(For Program in Item 1)		
	2. PATIENT'S NAME (Last Name		(Member IC	3. PATIENT'S BIRTH DA	(ID#) (ID#) TE SEX	123 45 6789A 4. INSURED'S NAME (Last Name, First Name, Middle Initia)) 7. INSURED'S ADDRESS (No., Street)					
	Smith, John A.				MX F						
	5. PATIENT'S ADDRESS (No., S 123 Main Street	Street)		6. PATIENT RELATIONS	Child Other	7. INSURED'S ADDRI	SS (No., Stre	et)			
	CITY		STATE MA	8. RESERVED FOR NU		СПУ	,		STATE		
	ZIP CODE	TELEPHONE (Include Area				ZIP CODE	Т	ELEPHONE	(Include Area Code)		
	12345	(555) 555-555)		
	9. OTHER INSURED'S NAME (L	.ast Name, First Name, Middle	Initial)	10. IS PATIENT'S CONE	TION RELATED TO:	11. INSURED'S POLIC	Y GROUP O	R FECA NU	MBER		
	a. OTHER INSURED'S POLICY	OR GROUP NUMBER		a. EMPLOYMENT? (Cur		a. INSURED'S DATE			SEX _		
	b. RESERVED FOR NUCC USE			b, AUTO ACCIDENT?	PLACE (State	b. OTHER CLAIM ID (Designated by	M (NUCC)	F		
				YES							
	c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?	NO	c. INSURANCE PLAN	NAME OH P	IOGHAM N	AME		
	d. INSURANCE PLAN NAME OF	R PROGRAM NAME		10d. CLAIM CODES (De	ignated by NUCC)	d. IS THERE ANOTHE					
	12. PATIENT'S OR AUTHORIZE	BACK OF FORM BEFORE C	OMPLETING	& SIGNING THIS FORM		13. INSURED'S OR A	JTHORIZED F	PERSON'S	e items 9, 9a, and 9d. SIGNATURE I authorize		
	12. PATIENT'S OR AUTHORIZE to process this claim. I also rec balow.	Quest payment of government b	authorize the r enefits either t	elease of any medical or o o myself or to the party wh	ter information necessary accepts assignment	payment of medica services described	I benefits to the	ie undersigr	ned physician or supplier for		
	SIGNED			DATE		SIGNED					
	14. DATE OF CURRENT ILLNES	SS, INJURY, or PREGNANCY	(LMP) 15.0	THER DATE	I DD I YY	16. DATES PATIENT	UNABLE TO V	VORK IN CI TO	JRRENT OCCUPATION		
	17. NAME OF REFERRING PRO		17a.				DATES REL		URRENT SERVICES		
	19. ADDITIONAL CLAIM INFOR	MATION (Declarated by NUC	176.	NPI		FROM 20. OUTSIDE LAB?		то	ARGES		
		in their (beerginates by thee	~	· ·			NO				
· · ·					D Ind. 0	22. RESUBMISSION		RIGINAL RI	EF. NO.		
	21. DIAGNOSIS OR NATURE OF	FILLNESS OR INJURY Relat	le A-L to servi	ce line below (24E) IC	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CODE					
		FILLNESS OR INJURY Relat	e A+C to servi C. L G. L	ce line below (24E) IC	D. L	23. PRIOR AUTHORI		3ER			
		B	с. L g. L К. L		D	23. PRIOR AUTHORI	ATION NUME		J.		
	21, DIACNOSIS OR NATURE OF A	B	C. L. G. L. K. L. D. PROCEI	DURES, SERVICES, OR :	D. L. L. L. DIAGNOSI	23. PRIOR AUTHORI	G. P	SER H. L. SOT ID. Infly QUAL.	J. RENDERING PROVIDER ID. #		
	21. DMCMOSIS OR NATURE OF A. XX''X'' E. L I. L 24. A. DATE(S) OF SERVIC FROM YY MM (1) 1	B. F. J. To PLACEOF DD YY SERVICE EMG	C. L. G. L. K. L. D. PROCEI (Explai CPT/HCPC	DURES, SERVICES, OR 1 in Unusual Circumstances CS MODIF		23. PRIOR AUTHORI	G. DAYS EP OR Fa UNITS P	H. I. May ID. In QUAL.	PROVIDER ID, #		
	21 DRGNOSE OF NATURE OF A XX''X'' E 24.A DATES) OF SERVE Plan MU DO VY MM 1 01 01 22 01 1	B. B. C. C. PLACE OF DD YY SERVICE EMG 01 22 24	C. L. G. L. K. L. D. PROCEL (Explai CPT/HCPC 6698	DURES, SERVICES, OR I In Unusual Circumstances IS MODIF	D. L. L. DIAGNOSI ER POINTER	23. PRIOR AUTHORI	G I DAYS EP OR FR UNTS P	H. L. SOT ID. mty QUAL.	PROVIDER ID. # 1234567890		
	21 DRGNOSE OF NATURE OF A XX''X'' E E 24 A DATES) OF SERVE Pan MU DO VY MM 1 01 01 22 01 1	B. F. J. To PLACEOF DD YY SERVICE EMG	C. L. G. L. K. L. D. PROCEI (Explai CPT/HCPC	DURES, SERVICES, OR I In Unusual Circumstances IS MODIF	D. L. L. DIAGNOSI ER POINTER	23. PRIOR AUTHORI	G. DAYS EP OR Fa UNITS P	H. I. May ID. In QUAL.	PROVIDER ID, #		
	21 DRGNOSE OF NATURE OF A XX''X'' E E 24 A DATES) OF SERVE Pan MU DO VY MM 1 01 01 22 01 1	B. B. C. C. PLACE OF DD YY SERVICE EMG 01 22 24	C. L. G. L. K. L. D. PROCEL (Explai CPT/HCPC 6698	DURES, SERVICES, OR I In Unusual Circumstances IS MODIF	D. L. L. DIAGNOSI ER POINTER	23. PRIOR AUTHORI	G I DAYS EP OR FR UNTS P	H. L. SOT ID. mty QUAL.	PROVIDER ID. # 1234567890		
	21 DRGNOSE OF NATURE OF A XX''X'' E E 24 A DATES) OF SERVE Pan MU DO VY MM 1 01 01 22 01 1	B. B. C. C. PLACE OF DD YY SERVICE EMG 01 22 24	C. L. G. L. K. L. D. PROCEL (Explai CPT/HCPC 6698	DURES, SERVICES, OR I In Unusual Circumstances IS MODIF	D. L. L. DIAGNOSI ER POINTER	23. PRIOR AUTHORI	G I DAYS EP OR FR UNTS P	H, I. NPT ID. QUAL, NPT NPT NPT NPT	PROVIDER ID. # 1234567890		
	21 DIPCROSPE OF NATURE OF XX*X* 24 A DATE(S) OF SERVIC 101 01 22 01 0 201 01 22 01 0 3	B. B. C. C. PLACE OF DD YY SERVICE EMG 01 22 24	C. L. G. L. K. L. D. PROCEL (Explai CPT/HCPC 6698	DURES, SERVICES, OR I In Unusual Circumstances IS MODIF	D. L. L. DIAGNOSI ER POINTER	23. PRIOR AUTHORI	G I DAYS EP OR FR UNTS P	H IL SHT ID. QUAL NPI NPI NPI NPI NPI	PROVIDER ID. # 1234567890		
	21 BIACANGER OR NATURE OF 22 DI CONSTRUCTION OF CONTROL 24 A DATES OF CONTROL 24 A DATES OF CONTROL 25 A DATES OF CONTROL 20 1 01 22 01 1 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	B. B. C. C. PLACE OF DD YY SERVICE EMG 01 22 24	C. L. G. L. K. L. D. PROCEL (Explai CPT/HCPC 6698	DURES, SERVICES, OR I In Unusual Circumstances IS MODIF	D. L. L. DIAGNOSI ER POINTER	23. PRIOR AUTHORI	G I DAYS EP OR FR UNTS P	H, I. NPT ID. QUAL, NPT NPT NPT NPT	PROVIDER ID. # 1234567890		
	21 BIACHONGER OR NATURE OF 22 A DATE(5) OF SERVIC 24 A DATE(5) OF SERVIC 101 01 22 01 1 2 01 01 22 01 1 3 4 4 5 6	B B C C C C C C C C C C C C C C C C C C	C. L G. L K. L D. PROCEI (Explaid CPT/HCPC		D. L. E. DIAGNOS BR POINTER A A	23. PRIOR AUTHOR:		H L SOT ID. TO UD. V QUAL NPI NPI NPI NPI NPI NPI NPI	PROVIDER ID. #		
	21 BIACANGER OR NATURE OF 22 DI CONSTRUCTION OF CONTROL 24 A DATES OF CONTROL 24 A DATES OF CONTROL 25 A DATES OF CONTROL 20 1 01 22 01 1 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	B B C C C C C C C C C C C C C C C C C C	C. L. G. L. K. L. D. PROCEL (Explai CPT/HCPC 6698		D. L. L. DIAGNOSI ER POINTER	23. PRIOR AUTHORI		H. I. SOT ID. NPI QUAL NPI NPI NPI NPI NPI	PROVIDER ID. #		
	21 BIACHONGER OR NATURE OF 22 A DATE(5) OF SERVIC 24 A DATE(5) OF SERVIC 101 01 22 01 1 2 01 01 22 01 1 3 4 4 5 6		C. L G. L K. L D. PROCEI (Esplaid CPT/HOP/ 66898 68884			23. PRICH AUTHOR; 5. F. 5. CHARGES	SATION NUMBER	NPI NPI NPI NPI NPI NPI NPI NPI	PROVIDER ID. #		

*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.

HCPCS = Healthcare Common Procedure Coding System.





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

Box 42, 43				2			3a PAT.	1234		4 TYPE OF BILL
-		Any Hospital			Hospital		5a PAL CNTL # b. MED. REC. #			0131
Enter revenue code and revenue code		123 Any Street	-		Any Street		5 FED. TAX NO.	6 STATE FROM	MENT COVERS PERIOD THROUGH	7
description for the type of ophthalmic		Any Town, MA 1234	5 Doe, John		9 PATIENT ADDRESS 8	123 Any S	treet			
		>			Any Town	120 Ally 5	ueet	с	MA 1234	5 •
surgery (e.g., cataract, as shown here)		0 BIRTHDATE 11 SEX 12 DAT	ADMISSION E 13 HR 14 TYPE	15 SRC 16 DHR	17 STAT 18 19 20	21 22 CONDITIO	N CODES 23 24 21	26 27 1	8 29 ACDT 30 STATE	
and DEXTENZA.	1	OZ/Z1/1934	ENCE 33 OCC	URRENCE	01 34 ODCURRENCE	OCCURREN	CE SPAN THROUGH	36 OCCU CODE FRO	RENCE SPAN	37
and DEATEINZA.			0002	0.44	0002 0002 00			0000 110		
		18				39 VALU	E CODES VOUNT	40 WLUE COD	S 41	WLUE CODES AMOUNT
						a		CODE AMOON	CODE	AMOUNT
Box 44						b c				
						d				
Enter the procedure code to		Cataract Surge	erv		44 HCPCS / RATE / HIPPS CODE	45 SERV. DAT		TS 47 TOTAL CHA	IGES 48 NON-C	OVERED CHARGES 49
designate estaract surgary	2	DEXTENZA Ad	dministration		68841	1/1/2	2 _1	-		2
designate cataract surgery.	3	DEXTENZA In	sert		J1096	1/1/2	2 4			3
	5									5
										6
Box 44	7									7
	•									9
Enter the CPT* code for the surgical	10									10
procedure (e.g., 66984). Enter the	12									12
	13									13
HCPCS code to represent DEXTENZA	15									15
J-code (J1096) and the CPT code	16									16
	10									10
(68841) for DEXTENZA insertion.	19									19
	21									21
	2	PAGE OF			CREATION D		TOTAL	8 1		22
Box 46		IO PAYER NAME	51	HEALTH PLAN ID		53 ASO 54 PRIOR PAYME			88 NPI 12345	67890
		Medicare							57 TTHER	A
Enter a unit of 1 for the procedure	a								PRV ID	c
codes (66984 and 68841). Enter a		Doe, John		59 P.REL 60	ABC12345678	00	61 GROUP NAME		52 INSURANCE GROUP M	10.
		Doe, John		10	ABC12343070	00				•
unit of 4 for the DEXTENZA HCPCS	d	IN TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NU	MOED		65 EMPLOYER NAME		c
code (J1096). The HCPCS descriptor	-	a meninen annonentari auto			OF DOCUMENT CONTROL NO	MULA		US ENFECTER NAME		A
										8
for DEXTENZA is 0.1mg.		.xx"x" A	В	С		E	F	G		68
		9 ADMIT 70 PATIENT	K		71 PPS	72	0	P	Q	
	-	29 ADMIT 70 PATIENT DX PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROC	EDURE	C 71 PPS CODE b. OTHER PROCEDURI	E 75	76 ATTENDING	NPI	C QUAL	
Box 67		OTHER PROCEDURE	A OTHER PROC	FOURE	OTHER PROCEDURY	F	LAST		FIRST	
		CODE DATE	d. OTHER PROC	DATE	e. OTHER PROCEDURI CODE D	ĀTE	77 OPERATING LAST	NPI	FIRST	
Enter the appropriate ICD ⁺ -10 code(s).		10 REMARKS		81CC a			78 OTHER	NPI	QUAL	
		DEXTENZA, 7038202 Ophthalmic insert, 1/		c b			LAST 79 OTHER	NPI	FIRST	
	[1 insert, 0.4 mg	CIVED ONE HO 1000	d			LAST	IONS ON THE REVERSE (FIRST	DE MADE A DADT UPDECE
		HETT			NUBC Manada	nina LIC9213257	Concession of Report	terre over the new ender		and an of a rest of the left.

*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.

† International Classifications of Diseases (ICD).

HCPCS = Healthcare Common Procedure Coding System.







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	APPROVED BY NATIONAL UNFORM CLAIM COMMITTEE (NUCC) (2012
Enter "0" for ICD-10-CM.	1. MEDICARE MEDICALD TRICARE CHAMPVA GROUP X (Medicare/) (Medica
	2. PATIENTS NAME (Last Name, First Name, Middle Initial) 3. PATIENTS BIRTH QATE Smith, John A. 4. INSURED'S NAME (Last Name, First Name, Middle Initial) M D I VIII F
Box 24A	S. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No. Street) 123 Main Street Self X Spoule Child Other
	CITY STATE 0. RESERVED FOR NUCCUSE CITY STATE 0.
Enter N4 qualifier and 11-digit NDC	ZIP CODE TELEPHONE (Include Area Code) 12345 (555) 555-5555
code: N470382020401 UN1.†	9. OTHER INSURED'S NAME (Last Name, Frat Name, Midde Initia) 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) VES NO VES NO VES NO
Box 24B	b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? PLACE (State) b. OTHER CLAIM ID (Designaded by NUCC) YES NO YES
"11" indicates Office.	C, RESERVED FOR NUCCUSE C, OTHER ACCIDENT?
	4. INSURANCE PLAN NAME OR PROGRAM NAME 104. CLAIM CODES (Designated by NUCC) 4. IS THERE ANOTHER HEALTH BENEFIT PLAN?
Box 24D	READ BLCK OF FORM BEFORE COMPLETING A SIONING THE FORM. 12. PATIENTS OF ALTIVENZED FERSON'S SIGNATURE: Listencia in models or other information negative to process this claim. Labo request payment of government benefits either to mybell or to the party who accepts assignment to process this claim. Labo request payment of government benefits either to mybell or to the party who accepts assignment to process this claim. Labo request payment of government benefits either to mybell or to the party who accepts assignment to process this claim. Labo request payment of government benefits either to mybell or to the party who accepts assignment to process this claim. Labo request payment of government benefits either to mybell or to the party who accepts assignment to process the claim.
Enter the CPT [‡] code for DEXTENZA	SIGNED DATE SIGNED
	14. DATE OF CURRENT LUNESS, HULUNY, OF PEGNANCY (LIMP) 15. OTHER DATE MM DD YY 16. DATES PATERT UNALLE TO WORK IN CURRENT OCCUPATION QUAL AND DY FROM TO
insertion (68841), HCPCS code to	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17. MR DO TY 17. NR PROVIDER OR OTHER SOURCE 17. NR DO TY 17. NR PROVIDER OR OTHER SOURCE
represent DEXTENZA (J1096) and	19. ADDITIONAL CLAIM INFORMATION (Disignate) by NUCC) 20. OUTSIDE LAB? \$ CHARGES
the relevant modifiers to indicate	21. DMXCMOSHS OR NATURE OF ILLINESS OR INJURY Relative AC to service line below (24E) ICD Ind. 0 22. ESSUBAUSSION ORIGINAL REF. NO.
location and date of insertion.	
**Please refer to the possible	24. A. DATE(S) OF SERVICE: B. C. D. PROCEDURES, SERVICES, OS SUPPLES E. F. G. H. L J. PR0 TO FV2C9F Explain Thusaid Crismatarea) DIAGNOSIS DV307 D. PEVDETING MM
applicable modifiers.	1 01 02 22 01 02 22 11 68841 A XXX XX 1 MP 1234567890
	2 N470382020401 UNI 01 02 22 01 02 22 11 J1096 A XXX XX 4 A A XXX XX 4
	4
Box 24F	5 NPT
Enter price of DEXTENZA from price schedule.	
	→ →
	SI: SIGMATURE OF PHYSICIAN OR SUPPLIER INCLUDING DECERS OR CREDENTLALS INCLUDING DECENSION DE INVESSE INTERNAL SECONDENT
Box 24G	Anytown, MA 12345
Enter a unit of 1 for each procedure code	SIGNED DATE ^{a.} NPI ^{b.} NPI ^{b.} NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0338-1197 FORM 1500 (02-12)
(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.

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.







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

Box 21		नि/भाग							
Enter the appropriate ICD*-10 code(s).									ARRIER →
Box 21		PICA	INIFORM CLAIM COMMITTEE	(NUCC) 02/12					
Enter "0" for ICD-10-CM.		1. MEDICARE MEDI	cald#) (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	(ID#) (ID#)	1a. INSURED'S I.D. NUMBE 123 45 6789A		(For Program in Item 1)
		Smith, John A.	lame, First Name, Middle Initial)	3	PATIENT'S BIRTH DA	MX F	4. INSURED'S NAME (Last		, Middle Initial)
Box 24A		5. PATIENT'S ADDRESS (N 123 Main Stree		6	Self X Spouse	Child Other	7. INSURED'S ADDRESS (I	No., Street)	
			TELEPHONE (Include Ar	MA	RESERVED FOR NU	CC USE	CITY ZIP CODE		STATE NOLLY
Enter N4 qualifier and 11-digit NDC		12345	(555) 555-55	555				() NRO
code: N470382020401 UN1.†		a. OTHER INSURED'S NAM	E (Last Name, First Name, Mide		EMPLOYMENT? (Cur		11. INSURED'S POLICY GR		=
		b. RESERVED FOR NUCC			AUTO ACCIDENT?	NO	b. OTHER CLAIM ID (Desig		
Box 24B		c. RESERVED FOR NUCCI]	YES	PLACE (State)	C. INSURANCE PLAN NAM		
"11" indicates Office.		d. INSURANCE PLAN NAM			YES	NO	d. IS THERE ANOTHER HE		
		B	FAD BACK OF FORM REFOR				YES NO	If yes, compl	ate items 9, 9a, and 9d.
Box 24D		12. PATIENT'S OR AUTHOR	IZED PERSON'S SIGNATURE o request payment of governmen	I authorize the rel t benefits either to	ase of any medical or o nyself or to the party wh	ther information necessary o accepts assignment	payment of medical bene services described below	fits to the undersi	gned physician or supplier for
Enter the CPT [‡] code for		SIGNED	NESS, INJURY, or PREGNANC	CY (LMP) 15. 01	DATE	I DD I YY	SIGNED	LE TO WORK IN	CURRENT OCCUPATION
DEXTENZA insertion (68841),		17. NAME OF REFERRING	QUAL. PROVIDER OR OTHER SOUR	1100	AUNI	00 11	FROM DD 18. HOSPITALIZATION DAT	т	
HCPCS code to represent		19, ADDITIONAL CLAIM INF	ORMATION (Designated by NU	JCC)	IPI		FROM 20. OUTSIDE LAB?	т	CHARGES
DEXTENZA (J1096) and the		21. DIAGNOSIS OR NATUR	E OF ILLNESS OR INJURY Re	state A-L to service	line below (24E)	:D Ind. 0	22. RESUBMISSION	. ORIGINAL I	REF. NO.
relevant modifiers to indicate		A	B. L	с. L G. L		в	23. PRIOR AUTHORIZATIO		
location and date of insertion.		24. A. DATE(S) OF SET	To PLACE OF	(Exolain	RES, SERVICES, OR		F. 0	3. H. L. YS EPSOT ID	J. RENDERING 8
**Please refer to the possible		1	DD YY SERVICE EMI	G CPT/HCPCS	MODIF	ER POINTER	\$ CHARGES UN	TS Plan QUAL	PROVIDER ID. #
applicable modifiers.		01 01 22 01 2 N47038202040	1 UNI	68841		A	XXX XX :		1234567890
applicable modifiers.		² 01 01 22 01 3	01 22 11	J1096		A	XXX XX 8	3 NPI	1234567890
		4						NPI	
Box 24F		5						NPI	CIAN C
Enter price of DEXTENZA from price sched	ايرام	6						NPI	KAHA
Enter price of DEXTENZA from price sched	aule.	25. FEDERAL TAX I.D. NUN	IBER SSN EIN 2	6. PATIENT'S AC		ACCEPT ASSIGNMENT?	28. TOTAL CHARGE S	29. AMOUNT P. \$	
Box 24G		31. SIGNATURE OF PHYSI INCLUDING DEGREES (I certify that the stateme apply to this bill and are to	CIAN OR SUPPLIER 3 OR CREDENTIALS of the reverse	2. SERVICE FACI	ITY LOCATION INFOR		33. BILLING PROVIDER IN Any Office 123 Anystreet Anytown, MA		23) 456-7890
Enter a unit of "1" for each 68841		SIGNED	DATE	NP			* NPI	b.	
procedure e.g., for bilateral procedures		NUCC Instruction Mar	ual available at: www.nu	ucc.org	PLEASE PR	INT OR TYPE	APPHOVE	D OMB-0938-	1197 FORM 1500 (02-12)

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.

‡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.



PATIENT ACCESS AND REIMBURSEMENT SERVICES

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.





PATIENT ACCESS AND REIMBURSEMENT SERVICES



