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.

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

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.MyOcuCare.com**.

PATIENT INFORMATION

Name (First, Middle and Last): ____ City: ____ State: ____ Date of Birth: ____
Address: ____ Email: ____ Zip Code: ____
Home Phone: ____ Cell Phone: ____

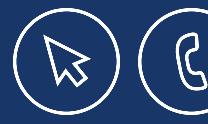
PATIENT INSURANCE INFORMATION (Please attach copy of medical insurance cards (both sides))

Patient is Uninsured: ☐ Yes ☐ No

PRIMARY INSURANCE Copy of insurance card attached: ☐ Yes ☐ No
Insurance Plan Name: ____ Group Number: ____ Phone Number: ____ Policy Number: ____
Plan Type/Sub Type: ____

SECONDARY INSURANCE Copy of insurance card attached: ☐ Yes ☐ No
Group Number: ____ Phone Number: ____ Policy Number: ____

Product Name: DEXTENZA® (dexamethasone ophthalmic insert) 0.4mg
Right Eye: ____ Left Eye: ____ Bilateral: ____
☐ ASC ☐ HCP Office



Click, Call, or Connect MyOcuCare.com

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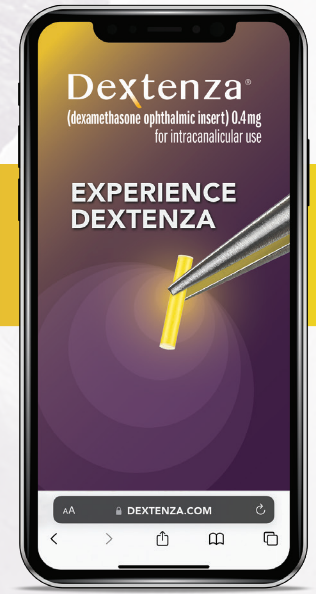
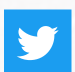


Connect to Us

www.DEXTENZA.com
www.MyOcuCare.com

 www.twitter.com/OCUTX

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.

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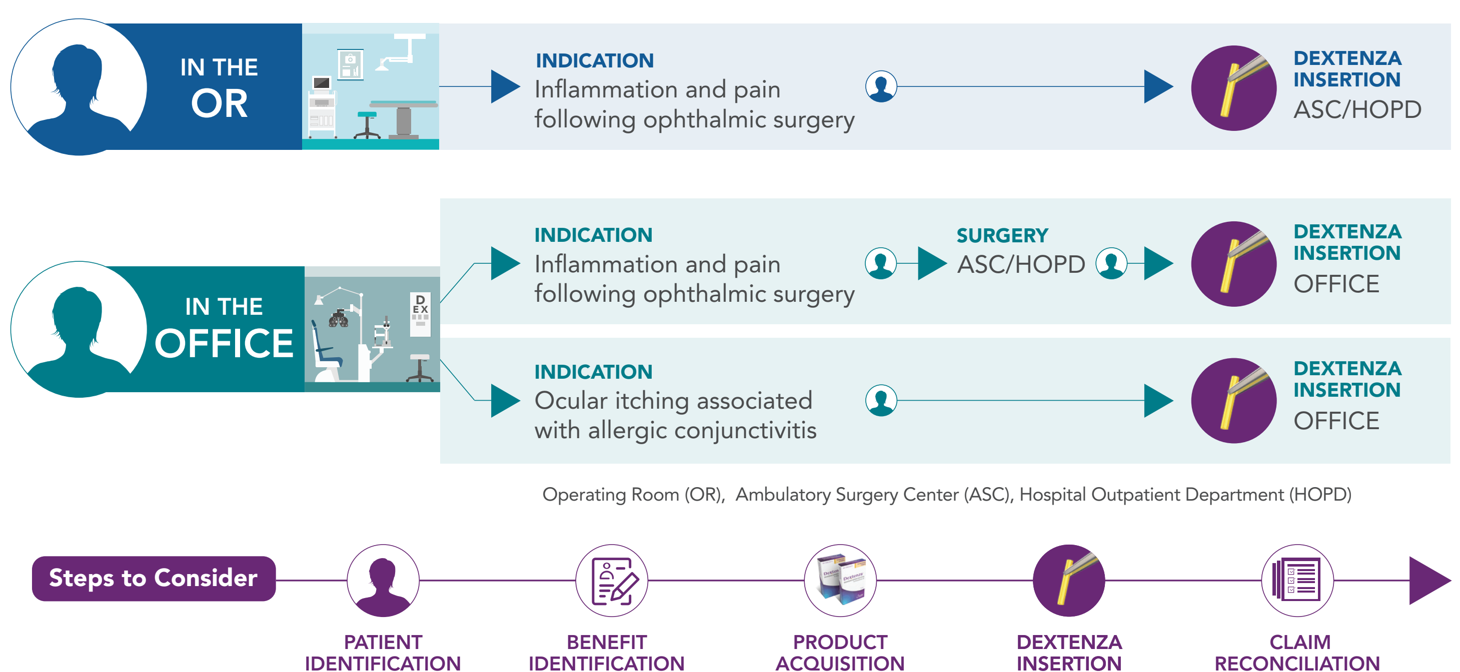
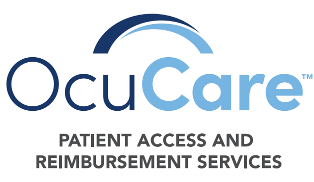
DEXTENZA Patient Journey



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.

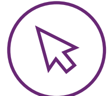


Reimbursement Roadmap

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

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

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 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	besse.com
Cardinal Specialty Pharma Distribution	1-855-855-0708	1-614-553-6301	cardinalhealth.com/specialtyonline
Metro Medical	1-800-768-2002	1-615-256-4194	metromedicalorder.com
McKesson Medical-Surgical	1-855-571-2100	1-800-311-3408	mms.mckesson.com
McKesson Plasma and Biologics for Hospitals	1-877-625-2566	1-888-752-7626	connect.mckesson.com

Ocular Therapeutix does not recommend the use of any particular distributor.

Product	Active Ingredient	Quantity	10-Digit NDC* Number†	11-Digit NDC Number‡
DEXTENZA (dexamethasone ophthalmic insert) 0.4 mg	(dexamethasone USP)	1	70382-204-01	70382-0204-01
DEXTENZA (dexamethasone ophthalmic insert) 0.4 mg	(dexamethasone USP)	10	70382-204-10	70382-0204-10

*NDC = National Drug Code

†10-Digit NDC code as assigned by FDA, certain payers accept the 10 digit format.

‡11-Digit NDC code that can be utilized for payers that require 11 digits or when ordering product.

Storage and Handling

How DEXTENZA is supplied[1]

DEXTENZA is supplied sterile in a foam carrier within a foil laminate pouch:

- NDC 70382-204-01 Carton containing 1 pouch (1 inserts)
- NDC 70382-204-10 Carton containing 10 pouches (10 inserts)

Proper storage and handling[1]

- Do not freeze. Store refrigerated, between 2°C and 8°C (36°F and 46°F)
- Protect from light, keep in package until use
- Do not use if pouch has been damaged or broken
- DEXTENZA is intended for single dose only

1. DEXTENZA [package insert]. Bedford, MA: Ocular Therapeutix, Inc.; 2021.

Product and Procedure Billing Codes

Product Reimbursement

As of January 1, 2023, DEXTENZA has separate payment in the ASC* setting due to meeting the criteria set forth in the non-opioid as a surgical supply provision by CMS.

Product Code	Description
J1096 J-code†	Dexamethasone, lacrimal ophthalmic insert, 0.1mg‡

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

Procedure Reimbursement

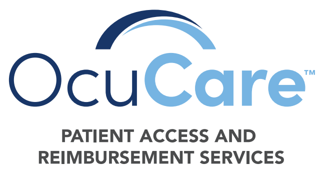
Procedure Code	Description
68841 CPT-code§	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed into lacrimal canaliculus, each)

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

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

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

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



ICD-10 Codes

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

This may not be a complete list of codes. Visit **https://www.cms.gov/medicare/icd-10/2023-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

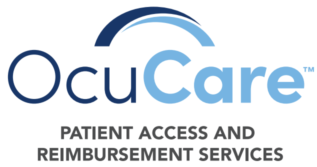
Allergic Conjunctivitis	General	Right Eye	Left Eye	Bilateral	Unspecified Eye
Acute atopic conjunctivitis	H10.1	H10.11	H10.12	H10.13	H10.10
Unspecified acute conjunctivitis	H10.3	H10.31	H10.32	H10.33	H10.30
Chronic conjunctivitis	H10.4	H10.401	H10.402	H10.403	H10.409
Chronic giant papillary conjunctivitis	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/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update** for a complete list of modifiers.

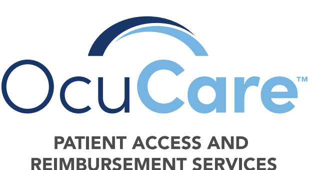
Possible Applicable Modifiers

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

Dextenza®
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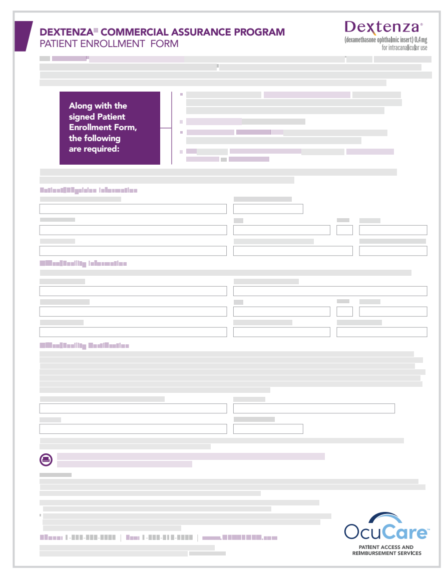
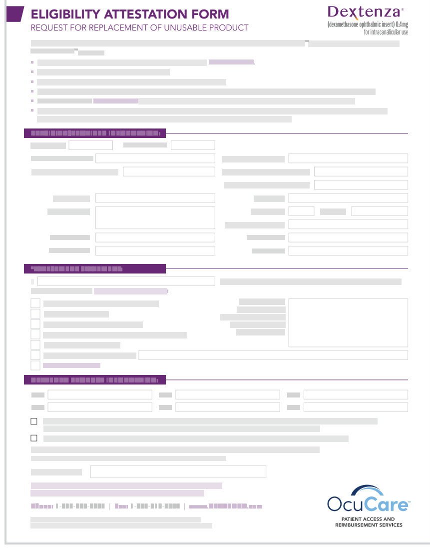
PATIENT ASSISTANCE PROGRAM (PAP)

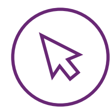


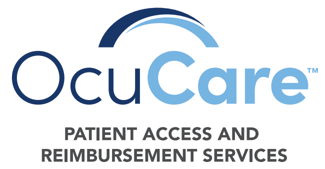
COMMERCIAL ASSURANCE PROGRAM (CAP)



PRODUCT REPLACEMENT PROGRAM

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





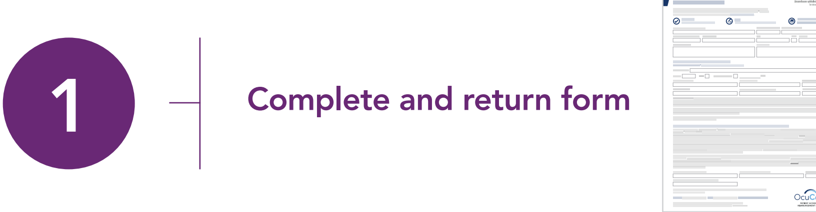
Patient Assistance Program (PAP) Application Information

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.

ACTION STEPS

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

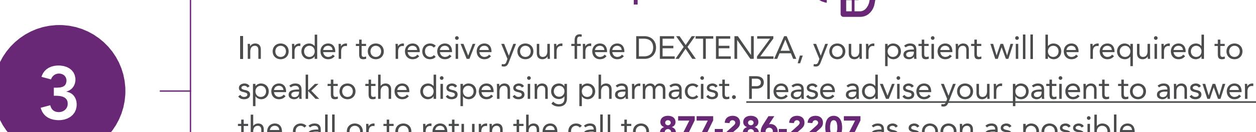


1 Complete and return form

2 Receive approval letter in the mail

If approved for a free DEXTENZA, you and your patient will be notified by OcuCare via mail and fax, respectively. Watch for this letter in the mail.

3 Connect with the OcuCare pharmacist



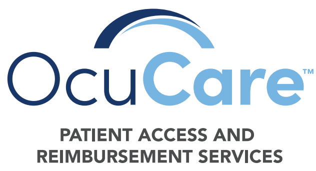
In order to receive your free DEXTENZA, your patient will be required to speak to the dispensing pharmacist. Please advise your patient to answer the call or to return the call to **877-286-2207** as soon as possible.

Note: Caller ID will display OcuCare and 1-877-286-2207.

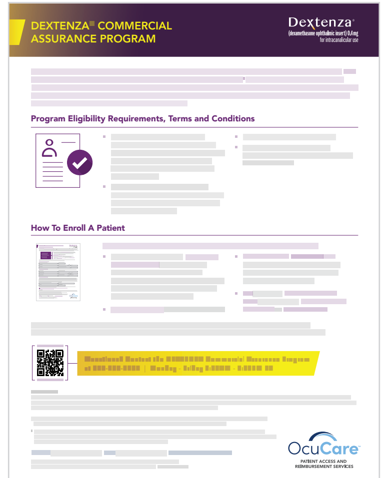
Your patients DEXTENZA prescription will be filled free of charge and shipped directly to the insertion site prior to your scheduled insertion date.

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.



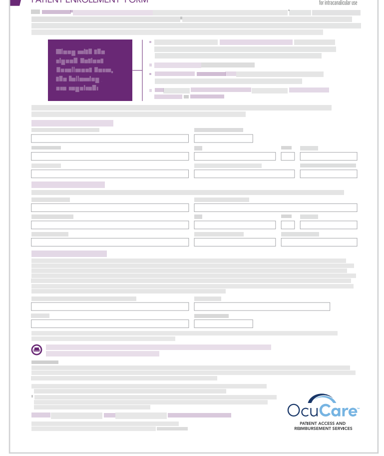
Commercial Assurance Program (CAP) Overview and Criteria



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 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 $555). 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:

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

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

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.

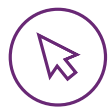
REPLACEMENT FORM

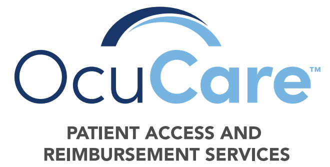
PLEASE NOTE:

- 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.





Comprehensive Support With OcuCare

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

MAKING OCUCARE SUPPORT CONVENIENT FOR YOU

Click, Call, or Connect MyOcuCare.com

MyOcuCare.com Portal

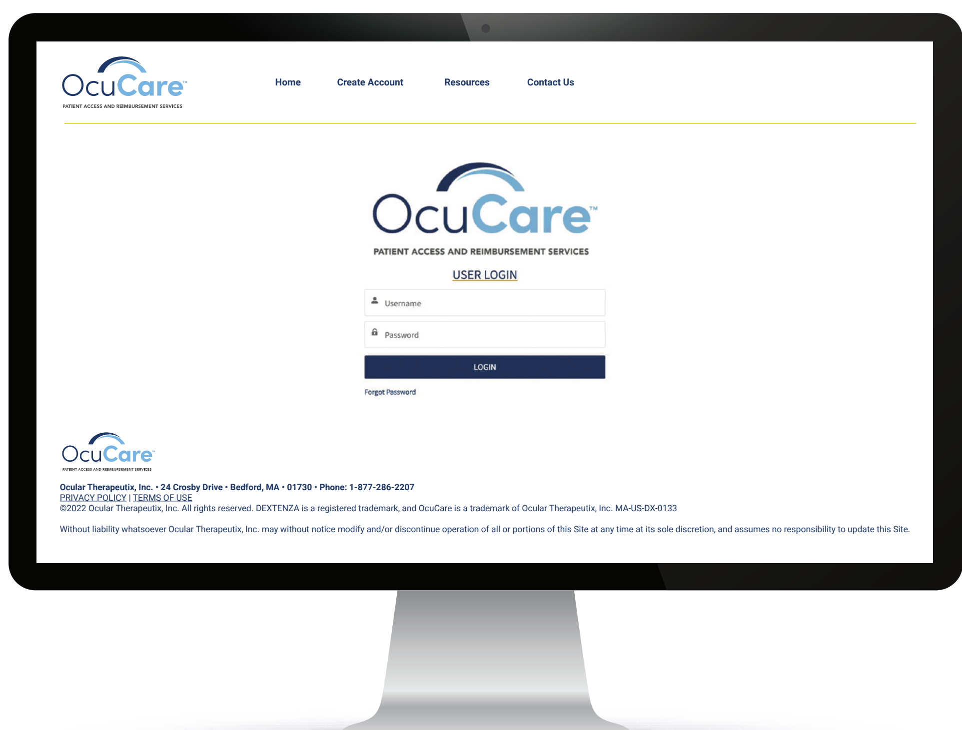
Create an account to seamlessly access your dedicated resource and support team.

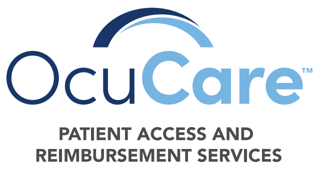
All Programs are Available on the Portal

- 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





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

Complete treatment information section

Complete prescriber and site of insertion information

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

PATIENT ENROLLMENT FORM

Dextenza® (dexamethasone ophthalmic insert) 0.4mg 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.MyOcuCare.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#: ______ PTAN: ______
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 OcuCare™ program, Ocular Therapeutix, and the patient's health insurers to determine the patient's insurance benefits for DEXTENZA. I also authorize Ocular's OcuCare 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: 1-877-286-2207 | **Fax:** 1-855-518-7564 | **www.DEXTENZA.com**

OcuCare™ PATIENT ACCESS AND REIMBURSEMENT SERVICES

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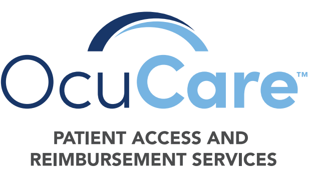
Submit the form via **www.MyOcuCare.com*** or **fax 1-855-518-7564**

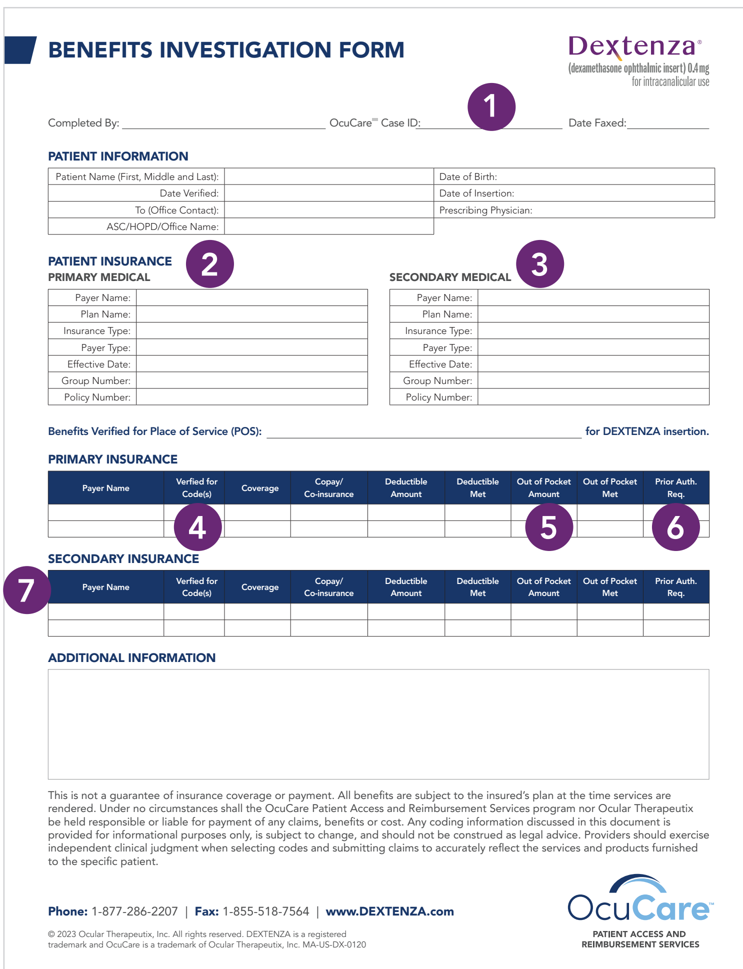
*A secure, online portal and convenient option to enroll and manage patients in OcuCare support programs. Provides instant access to patient case status updates 24 hours a day, 7 days a week. Registration Required.



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
2. **Primary Medical:** OcuCare will verify patient's primary insurance coverage
3. **Secondary Medical:** OcuCare will verify patient's secondary 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



BENEFITS INVESTIGATION FORM

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

Completed By: ______ OcuCare™ Case ID: ______ (1) Date Faxed: ______

PATIENT INFORMATION

Patient Name (First, Middle and Last):		Date of Birth:	
Date Verified:		Date of Insertion:	
To (Office Contact):		Prescribing Physician:	
ASC/HOPD/Office Name:			

PATIENT INSURANCE (2)

PRIMARY MEDICAL

Payer Name:	
Plan Name:	
Insurance Type:	
Payer Type:	
Effective Date:	
Group Number:	
Policy Number:	

SECONDARY MEDICAL (3)

Payer Name:	
Plan Name:	
Insurance Type:	
Payer Type:	
Effective Date:	
Group Number:	
Policy Number:	

Benefits Verified for Place of Service (POS): ______ for DEXTENZA insertion.

PRIMARY INSURANCE

Payer Name	Verfied for Code(s)	Coverage	Copay/ Co-insurance	Deductible Amount	Deductible Met	Out of Pocket Amount	Out of Pocket Met	Prior Auth. Req.
	(4)					(5)		(6)

SECONDARY INSURANCE (7)

Payer Name	Verfied for Code(s)	Coverage	Copay/ Co-insurance	Deductible Amount	Deductible Met	Out of Pocket Amount	Out of Pocket Met	Prior Auth. Req.

ADDITIONAL INFORMATION

This 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.

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

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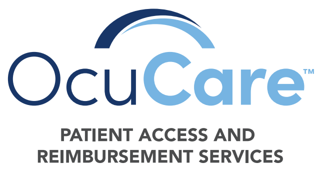
OcuCare™ PATIENT ACCESS AND REIMBURSEMENT SERVICES

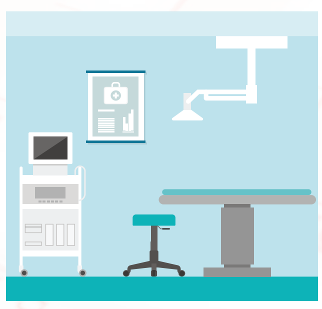
NOTE: The Benefits Investigation Form is not a guarantee of insurance coverage or payment. All benefits are subject to the insured's plan at the time services are rendered. Under no circumstances shall the OcuCare Patient Access and Reimbursement Services program nor Ocular Therapeutix be held responsible 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

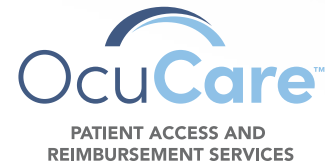
IN THE OFFICE

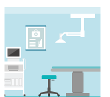
- Professional CMS-1500 Claim Form for Post-Surgical DEXTENZA Insertion in the Office Setting
- Professional CMS-1500 Claim Form for DEXTENZA Insertion for Non-Surgical Purposes in the Office Setting



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





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 the surgical procedure (e.g., 66984), 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 code (66984). 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

SAMPLE

1. MEDICARE: X (Medicare#)
1a. INSURED'S I.D. NUMBER: 123 45 6789A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A.
3. PATIENT'S BIRTH DATE / SEX: M X
5. PATIENT'S ADDRESS (No., Street): 123 Main Street
6. PATIENT RELATIONSHIP TO INSURED: Self X
CITY: Anytown
STATE: MA
ZIP CODE: 12345
TELEPHONE (Include Area Code): (555) 555-5555
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: A. .XX"X"
ICD Ind.: 0

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 01 22	01 01 22	24	66984	A	XXX XX	1	NPI	1234567890
N470382020401 UNI								
2 01 01 22	01 01 22	24	J1096	A	XXX XX	4	NPI	1234567890

25. FEDERAL TAX I.D. NUMBER: EIN X
27. ACCEPT ASSIGNMENT?: YES X
33. BILLING PROVIDER INFO & PH #: (123) 456-7890
Any ASC
123 Anystreet
Anytown, MA 12345
NPI

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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.

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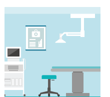
OcuCare™
PATIENT ACCESS AND REIMBURSEMENT SERVICES



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).

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

SAMPLE

1. MEDICARE [X] (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123 45 6789A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A.
3. PATIENT'S BIRTH DATE / SEX: M [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Main Street
CITY: Anytown STATE: MA
ZIP CODE: 12345 TELEPHONE (Include Area Code): (555) 555-5555
6. PATIENT RELATIONSHIP TO INSURED: Self [X]
7. INSURED'S ADDRESS (No., Street)
8. RESERVED FOR NUCC USE
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
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? $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. .XX"X"
22. RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN [X]
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? YES [X]
28. TOTAL CHARGE $ 29. AMOUNT PAID $ 30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
32. SERVICE FACILITY LOCATION INFORMATION a. NPI
33. BILLING PROVIDER INFO & PH # (123) 456-7890
Any ASC
123 Anystreet
Anytown, MA 12345
a. NPI

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*International Classifications of Diseases (ICD).

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HCPCS = Healthcare Common Procedure Coding System.

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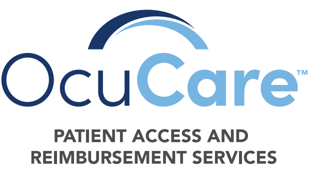
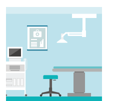




Facility CMS-1450 Claim form for DEXTENZA Insertion in ASC/HOPD

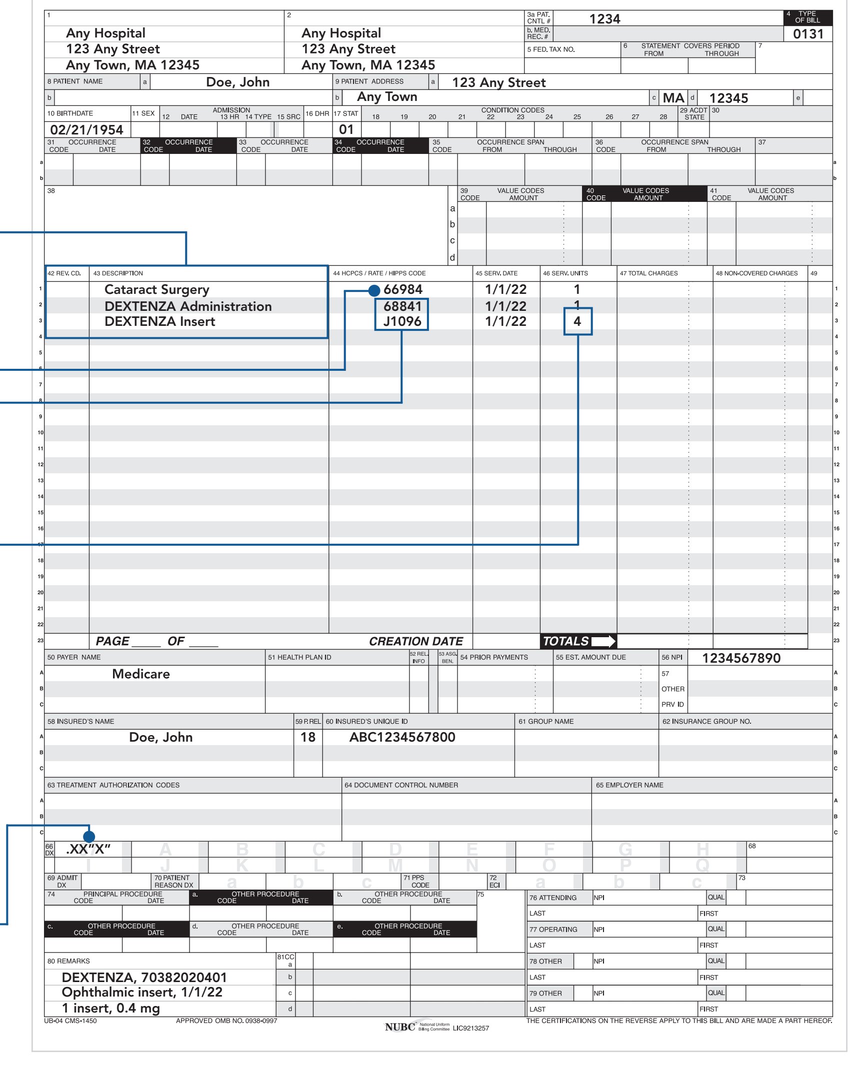
Box 42, 43
Enter revenue code and revenue code description for the type of ophthalmic surgery (e.g., cataract, as shown here) and DEXTENZA.

Box 44
Enter the procedure code to designate cataract surgery.

Box 44
Enter the CPT* code for the surgical procedure (e.g., 66984). Enter the HCPCS code to represent DEXTENZA J-code (J1096) and the CPT code (68841) for DEXTENZA insertion.

Box 46
Enter a unit of 1 for the procedure codes (66984 and 68841). Enter a unit of 4 for the DEXTENZA HCPCS code (J1096). The HCPCS descriptor for DEXTENZA is 0.1mg.

Box 67
Enter the appropriate ICD†-10 code(s).



1: Any Hospital, 123 Any Street, Any Town, MA 12345
2: Any Hospital, 123 Any Street, Any Town, MA 12345
3a PAT. CNTL #: 1234
4 TYPE OF BILL: 0131
8 PATIENT NAME: Doe, John
9 PATIENT ADDRESS: 123 Any Street, Any Town, MA 12345
10 BIRTHDATE: 02/21/1954
17 STAT: 01

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	Cataract Surgery	66984	1/1/22	1		
	DEXTENZA Administration	68841	1/1/22	1		
	DEXTENZA Insert	J1096	1/1/22	4		

PAGE ___ OF ___ CREATION DATE TOTALS

50 PAYER NAME: Medicare
56 NPI: 1234567890
58 INSURED'S NAME: Doe, John
59 P. REL: 18
60 INSURED'S UNIQUE ID: ABC1234567800
66 DX / 67: .XX"X"
80 REMARKS: DEXTENZA, 70382020401 Ophthalmic insert, 1/1/22 1 insert, 0.4 mg

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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† International Classifications of Diseases (ICD).

HCPCS = Healthcare Common Procedure Coding System.

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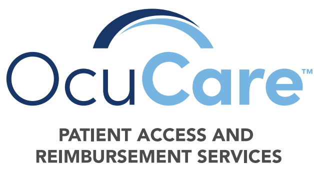

Professional CMS-1500 Claim Form for Post-Surgical DEXTENZA Insertion in the Office Setting

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

SAMPLE

1. MEDICARE: X (Medicare#)
1a. INSURED'S I.D. NUMBER: 123 45 6789A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A.
3. PATIENT'S BIRTH DATE / SEX: M X
5. PATIENT'S ADDRESS (No., Street): 123 Main Street
CITY: Anytown STATE: MA
ZIP CODE: 12345 TELEPHONE (Include Area Code): (555) 555-5555
6. PATIENT RELATIONSHIP TO INSURED: Self X

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

	24A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 02 22	01 02 22	11		68841		A	XXX XX	1	NPI	1234567890
2	N470382020401 UNI 01 02 22	01 02 22	11		J1096		A	XXX XX	4	NPI	1234567890
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: EIN X
27. ACCEPT ASSIGNMENT?: YES X
33. BILLING PROVIDER INFO & PH #: (123) 456-7890
Any Office
123 Anystreet
Anytown, MA 12345
32a. NPI
33a. NPI

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*International Classifications of Diseases (ICD).

†NDC is to be preceded with the qualifier N4 and followed immediately by the 11-digit NDC in positions 01 through 13. Quantity of NDC is to be preceded by the appropriate qualifier (UN = units) in positions 17 through 24.

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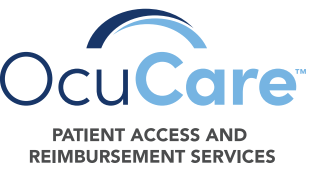

Professional CMS-1500 Claim Form for DEXTENZA Insertion for Non-Surgical Purposes in the Office Setting

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

SAMPLE

1. MEDICARE: X (Medicare#)
1a. INSURED'S I.D. NUMBER: 123 45 6789A
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A.
3. PATIENT'S BIRTH DATE / SEX: M X
5. PATIENT'S ADDRESS (No., Street): 123 Main Street
6. PATIENT RELATIONSHIP TO INSURED: Self X
CITY: Anytown   STATE: MA
ZIP CODE: 12345   TELEPHONE (Include Area Code): (555) 555-5555

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

Line	24A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 22	01 01 22	11	68841	A	XXX XX	2	NPI	1234567890
2	N470382020401 UNI 01 01 22	01 01 22	11	J1096	A	XXX XX	8	NPI	1234567890
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER: EIN X
27. ACCEPT ASSIGNMENT?: YES X
33. BILLING PROVIDER INFO & PH #: (123) 456-7890
Any Office
123 Anystreet
Anytown, MA 12345
a. NPI   a. NPI

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OcuCare™
PATIENT ACCESS AND REIMBURSEMENT SERVICES

Click here to return to Table of Contents

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

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