Dextenza 360™
Patient Access and Reimbursement Services

Phone: **1-800-339-8369**
**(800-DEXTENZA)**
Fax: **1-855-518-7564**
www.DEXTENZA360.com

# Enrollment Form for DEXTENZA® (dexamethasone ophthalmic insert) 0.4mg

This form should be completed by a prescriber and/or office staff or facility representative, signed by a prescriber, and submitted prior to surgery. When complete, please fax form, along with copies of the patient's medical and prescription drug insurance cards, both front and back to: **1-855-518-7564**. For electronic submission, visit www.Dextenza360.com.

## Section 1.1: Support Requested (check all that apply)

- ☐ Benefits Verification (**please submit at least 2 weeks prior to surgery**)
- ☐ Prior Authorization Assistance
- ☐ Appeals Support
- ☐ Claims Assistance
- ☐ Financial Assistance (additional form and patient signature required)

## Section 2.1: Patient Information

EMR Attached: ◯ Yes ◯ No Gender: ◯ M ◯ F

First Name: MI: Last Name:

Date of Birth: Home Phone: Cell Phone:

Address:

City: State: Zip Code: Email:

## Section 2.2: Patient Insurance Information (Please attach copy of medical and prescription drug insurance cards [both sides])

Patient is Uninsured: ☐

### Primary Insurance

**Copy of insurance card attached:** ◯ Yes ◯ No

Insurance Plan Name: Phone Number:

Employer:

Group Number: Policy Number:

Name of Policy Holder: Relationship to Policy Holder:

Policy Holder's DOB (if not patient):

### Secondary Insurance

**Copy of insurance card attached:** ◯ Yes ◯ No

Insurance Plan Name: Phone Number:

Employer:

Group Number: Policy Number:

Name of Policy Holder: Relationship to Policy Holder:

Policy Holder's DOB (if not patient):

### Prescription Drug Coverage

**Copy of prescription drug card attached:** ◯ Yes ◯ No

Rx Insurance Name: Rx Member ID #: Rx Phone:

PCN: BIN: Rx Group #:

Rx Policy Holder Name:





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

## Section 3.1: Treatment Information

Product Name: **DEXTENZA® (dexamethasone ophthalmic insert) 0.4mg**

Please include specific ICD-10 code(s): Right Eye Left Eye Bilateral

Surgery CPT: Date of Surgery(s): DEXTENZA Administration (CPT Code): **0356T**

DEXTENZA Insertion Site: HOPD ASC Other If checking Other, separate reimbursement for DEXTENZA may not apply. Please contact your DEXTENZA representative or DEXTENZA360 for more information.

## Section 4.1: Prescriber Information

Prescriber Name: Prescriber NPI#:

Office Name: Prescriber PTAN#:

Tax ID#:

Office Address (not PO Box):

City: State: Zip Code: Phone: Fax:

## Section 4.2: Office Contact Information

Primary Contact: Phone: Fax: Email:

## Section 4.3: Site of Surgery Information

Facility Name:

Site Contact Name: Direct Line: Email: Fax:

Facility NPI: Facility PTAN#: Facility Tax ID#:

Address (not PO box):

City: State: Zip Code: Phone: Fax:

## Section 4.4: Prescriber Authorization

I authorize the use or disclosure of the patient's health information contained on this enrollment form to Ocular's DEXTENZA360™ program, Ocular's Field Reimbursement Managers, and the patient's health insurers to determine the patient's insurance benefits for DEXTENZA . I also authorize Ocular's DEXTENZA360™ program to follow up with said health plan on my behalf to determine status of a prior authorization submitted on behalf of the patient and to assist with any claim denial appeals. I certify that I have obtained my patient's authorization as required by HIPAA to use and disclose patient's personally identifiable health information (including diagnosis, treatment, and insurance information, contained in this form), for the purposes permitted under this "Prescriber Authorization" Section. I agree that the patient's providers, insurers, and other designees may contact me for additional information as needed relating to the patient's DEXTENZA therapy. I certify that: I am the physician who has prescribed DEXTENZA to the identified patient; DEXTENZA is medically necessary for this patient; and the information provided on this form is accurate to the best of my knowledge.

Prescriber Signature: Date:

***(Valid only upon signature of licensed prescriber)***

***Please complete this form in it's entirety.***
***Submit the signed form via fax to 1-855-518-7564.***
***For electronic submission, visit www.Dextenza360.com.***