OPHTHALMOLOGY SPECIALTY CARE PROGRAM

Phone: **844-378-3784** • Fax: **888-972-7058**

1 PATIENT INFORMATION:

Name: ____________________

Address: ____________________

City: ____________ State: ____ Zip: ________

Phone: ____________ Alt. Phone: ____________

Email: ____________________

DOB: ________ Gender: ❍ M ❍ F Caregiver: ________

Height: ______ Weight: ______ Allergies: ________

2 PRESCRIBER INFORMATION:

Name: ____________________

Address: ____________________

City: ____________ State: ____ Zip: ________

Phone: ____________ Fax: ____________

NPI: ____________ DEA: ____________

Supervising Physician: ____________ NPI: ________

Tax I.D.: ____________________

Office Contact: ____________ Phone: ____________

v9.4_080119

© 2019 KloudScript, Inc. - All rights reserved.

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: ____________

ICD-10: ____________

Other: ____________

TB Test: ❑ Positive ❑ Negative Date: ________

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Serious or active infection present?	❑ Yes	❑ No
Does patient have latex allergy?	❑ Yes	❑ No
Hep B ruled out or treatment started?	❑ Yes	❑ No
History of malignancy?	❑ Yes	❑ No
History of MS or other demyelinating disease?	❑ Yes	❑ No
New onset CHF or worsening CHF?	❑ Yes	❑ No
Contraindication for antibiotics?	❑ Yes	❑ No

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Antibiotics	________
❑ Steroid Injections	________
❑ Immunosuppressants	________
❑ Methotrexate	________
❑ Others	________

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: ____________________ Patient's Date of Birth: ____________

Medication	Dosage & Strength	Direction	QTY	Refills
❑ HUMIRA®	❑ Uveitis Starter Pack	❑ **Induction Dose:** Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	3	0
	❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe ❑ 80mg/0.8ml Pen	❑ **Maintenance Dose:** Inject 40mg SC every other week ❑ Other: ________ ❑ *Patient has signed HUMIRA Complete form*	2	
	All strengths and dosages listed are Humira® Citrate Free			
❑ ________	________	________		
❑ ________	________	________		
❑ ________	________	________		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ____________________ Date: ________
Substitution Permitted

Signature: ____________________ Date: ________
Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.