Star Discount Pharmacy specialty care

Ophthalmology

Call: (877) 883-1392 Fax: (256) 919-0000

Patient Information: Name: ______________________________ DOB: _____________ Gender: ○M ○F

Address: ____ City: ________________________ State: ______ Zip: _____________

Phone: ___________________________ Alt. Phone: ______________ Email: ______________________________ Ht: ______ Wt: ______

Care Giver: ____________________________ Allergies: ○ No Known ○ See Attached Charts Other: ____________________________

Please include front and back copies of insurance card

Prescriber Information

Name: _________________________________ NPI: __________________ Phone: ___________________ Fax: ____________________

Address: ___________________________________ City: ________________ State:____ Zip:____________ Office Contact: ______________

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _______________ ICD-10: ___________________ Other: _____________ TB Test: ○Pos ○Neg Date: __________

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

Prior Failed Treatments	Drug Name and Length of Treatment
○ Antibiotics	
○ Steroid Injections	
○ Immunosuppressants	
○ Methotrexate	
○ Other	

Injection Training: ○Pharmacist to Provide Training ○Patient Trained in MD Office ○Manufacturer Nurse Support

Product Delivery: ○Patient's Home ○Physician's Office ○Pharmacy to Coordinate

Prescription Information:

Medication	Dosage	Directions	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 *All strengths and dosages listed are Humira Citrate Free*	2	
○	○	○		
○	○	○		

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: ____________________________ Signature______________________________ Date: ____________

Substitution Permitted **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.

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