Ophthalmology

Call: (877) 883-1392 Fax: (256) 429-2221

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: _____

Last 4 of SSN:

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
	○ 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
☐ Humira	○ 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.

Revised 10/15/2020