



# Ophthalmic Prescription/Pharmacy Intake Form

Phone: **888-347-3416**Fax: **866-586-7804****PATIENT INFORMATION** **NEW TO THERAPY** **THERAPY CONTINUATION**Patient's Name: \_\_\_\_\_  M  F

Daytime Phone: (\_\_\_\_) \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Evening Phone: (\_\_\_\_) \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

PCP Name: \_\_\_\_\_

 **DELIVER MEDICATION TO PHYSICIAN'S OFFICE**

PCP Phone: \_\_\_\_\_

 **DELIVER MEDICATION TO Other** Phone Number: \_\_\_\_\_Patient's Scheduled Appointment Date: \_\_\_\_\_ Date Delivery Needed: \_\_\_\_\_ Delivery Day Preference:  T  W  Th  F**INSURANCE INFORMATION** (Please include copy of front & back of insurance card if possible):

Provider/Plan: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Patient's I.D. Number: \_\_\_\_\_

Patient's Group Number: \_\_\_\_\_

Policyholder's Name (if not patient): \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Patient's I.D. Number: \_\_\_\_\_

Patient's Group Number: \_\_\_\_\_

Policyholder's Name (if not patient): \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**CLINICAL CRITERIA \*\*REQUIRED\*\*** Please check all that apply

Diagnosis Code: \_\_\_\_\_

**Affected eye:** Left eye Right eye Both eyes

Medication	Form	Strength/Dose	Qty	Directions/Frequency	Refills
Eylea®	SDV	<input type="checkbox"/> 2mg/0.05ml			
Jetrea®	SDV	<input type="checkbox"/> 1.25mg/ml			
Iluvien®	Implant	<input type="checkbox"/> 0.19 mg			
Lucentis®	Vial	<input type="checkbox"/> 0.3mg/0.05ml* <input type="checkbox"/> 0.5mg/0.05ml			
	PFS	<input type="checkbox"/> 0.5mg/0.05ml			
Ozurdex®	Implant	<input type="checkbox"/> 0.7mg			
Triesence®	Vial	<input type="checkbox"/> 40mg/ml			
Visudyne®	Vial	<input type="checkbox"/> 15mg			

\* Only for Certain diagnosis(Diabetic Macular Edema) E11.311

Prescriber's Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax: \_\_\_\_\_

State License # \_\_\_\_\_ DEA# \_\_\_\_\_ Physician NPI # \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

 **Substitution Permissible M.D.\*** In order for a brand name product to be dispensed, the prescriber must handwrite 'BRAND NECESSARY' or "BRAND MEDICALLY NECESSARY" in the space provided \_\_\_\_\_

\*as appropriate

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