

Ophthalmology Enrollment Form

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____
 Address _____
 Address 2 _____
 City, State, ZIP _____
 Home Phone _____ Alternate Phone _____
 DOB _____ Last Four of SS# _____ Gender _____
 Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
 DEA _____
 NPI _____
 Group/ Hospital _____
 Address _____
 City, State, ZIP _____
 Phone _____ Fax _____
 Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

Diagnosis — Please include diagnosis name with ICD-10 code

E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
 H35.32 Exudative age-related macular degeneration
 H35.81 Retinal edema
 Other Diagnosis: ICD-10 Code _____
 Description _____
 Date of Diagnosis _____

Additional Information Therapy: New Reauthorization Restart

Weight _____ kg/ lbs Height _____ cm/in
 Allergies _____
 Lab Data _____
 Concomitant Medications _____
 Additional Comments _____

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/>				

* Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: Patient Office Other _____ Date _____ Needs by Date _____
 Product Substitution permitted Dispense as Written
 Prescriber's Signature _____ Date _____

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