

**OPHTHALMOLOGY SPECIALTY CARE PROGRAM**

Phone: **417-717-0062** • Fax: **888-974-1277**

**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: \_\_\_\_\_  
 Tax I.D.: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Date of Diagnosis: \_\_\_\_\_ Serious or active infection present?  Yes  No  
 ICD-10: \_\_\_\_\_ Does patient have latex allergy?  Yes  No  
 Other: \_\_\_\_\_ Hep B ruled out or treatment started?  Yes  No  
 History of malignancy?  Yes  No  
 TB Test:  Positive  Negative Date: \_\_\_\_\_ 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 \_\_\_\_\_

**If Prior Authorization is Denied:**

- Automatically Draft Appeal for Review
- Send Preferred Formulary Alternatives

**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	
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> Uveitis Starter Pack	<input type="checkbox"/> <b>Induction Dose:</b> Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 40mg SC every other week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient has signed HUMIRA Complete form	4	0
	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe		2	
<input type="checkbox"/> _____	_____	_____		
<input type="checkbox"/> _____	_____	_____		
<input type="checkbox"/> _____	_____	_____		

**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: \_\_\_\_\_ 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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