PHARMACA
SPECIALTY PHARMACY

OPHTHALMOLOGY ENROLLMENT FORM

Fax: **888-882-3341**
Call 24/7: **855-465-8892**

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt Phone: _____
Email: _____
DOB: _____ ☐ M ☐ F Last 4 of SSN: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Office Contact: _____ Phone: _____

3 INSURANCE INFORMATION:

Please attach front and back copies of prescription/medical insurance card(s).

4 CLINICAL INFORMATION:

To expedite prior authorization, please attach relevant clinical documentation.

Primary ICD-10: _____ Drug Allergies: ☐ NKDA ☐ _____

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: _____

5 INJECTION TRAINING:

☐ Physician to Train ☐ Pharmacist to Train ☐ Other: _____

6 PRODUCT DELIVERY:

☐ Physician's Office ☐ Patient's Home ☐ Other: _____

PRESCRIPTION INFORMATION:

Medication	Dose/Strength	Directions	Qty	Refills
☐ **Humira®**	☐ Uveitis Starter Pack ☐ 40mg/0.8ml Pen ☐ 40mg/0.8ml Prefilled Syringe	☐ **Induction:** Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	4	0
		☐ **Maintenance:** Inject 40mg SC every other week ☐ **Other:** _____	2	
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

X PHYSICIAN SIGNATURE REQUIRED

Substitution Permitted | Date | Dispense as Written | Date