PHARMACA
SPECIALTY PHARMACY

# OPHTHALMOLOGY ENROLLMENT FORM

Fax: **888.882.3341**
Call: **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 and Form | Directions | Qty | Refills |
|---|---|---|---|---|
| ☐ **Humira** | ☐ Uveitis Starter Pack<br>☐ 40 mg/0.8 mL Pen<br>☐ 40 mg/0.8 mL Prefilled Syringe | ☐ **Induction:** Inject 80 mg SC on day 1, then 40 mg SC on day 8, then 40 mg SC every other week | 4 | 0 |
| | | ☐ **Maintenance:** Inject 40 mg SC every other week<br>☐ **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.

PHYSICIAN SIGNATURE REQUIRED

X __________ Substitution Permitted | Date

X __________ Dispense as Written | Date

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