OPHTHALMOLOGY SPECIALTY CARE PROGRAM

Phone: **888-570-4487** • Fax: **844-899-4226**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

v9.3_082918

❶ PATIENT INFORMATION:

Name: ______
Address: ______
City: ______ State: ____ Zip: ______
Phone: ______ Alt. Phone: ______
Email: ______
DOB: ______ Gender: ❍ M ❍ F Caregiver: ______
Height: ______ Weight: ______ Allergies: ______

❷ PRESCRIBER INFORMATION:

Name: ______
Address: ______
City: ______ State: ____ Zip: ______
Phone: ______ Fax: ______
NPI: ______ DEA: ______
Tax I.D.: ______
Office Contact: ______ Phone: ______

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

Date of Diagnosis: ______
ICD-10: ______
Other: ______
TB Test: ❑ Positive ❑ Negative Date: ______

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Serious or active infection present? ❑ Yes ❑ No
Does patient have latex allergy? ❑ Yes ❑ No
Hep B ruled out or treatment started? ❑ Yes ❑ No
History of malignancy? ❑ Yes ❑ No
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	______

❹ INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

❺ PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

❻ 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
❑ HUMIRA®	❑ Uveitis Starter Pack	❑ **Induction Dose:** Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	3	0
	❑ 40mg/0.4ml Pen ❑ 40mg/0.4ml Prefilled Syringe ❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe ❑ 80mg/0.8ml Pen	❑ **Maintenance Dose:** Inject 40mg SC every other week ❑ Other: ______ ❑ *Patient has signed HUMIRA Complete form*	2	
❑ ______	______	______		
❑ ______	______	______		
❑ ______	______	______		

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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