Medley Pharmacy
Sinks Pharmacy
Towne Pharmacy
Steelville Drug
SpecialtyCAREServices

OPHTHALMOLOGY SPECIALTY CARE PROGRAM

Phone: 844-422-6400 • Fax: 888-850-4018

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

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:

Date of Diagnosis: _____

ICD-10: _____

Other: _____

TB Test: ❑ Positive ❑ Negative Date: _____

If Prior Authorization is Denied:
❑ Automatically Draft Appeal for Review
❑ Send Preferred Formulary Alternatives

(Please Attach All Medical Documentation)

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	_____

4 PRESCRIPTION INFORMATION:

(Please be sure to choose both induction and maintenance dose where applicable)

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	4	0
	❑ 40mg/0.8ml Pen ❑ 40mg/0.8ml Prefilled Syringe	❑ Maintenance Dose: Inject 40mg SC every other week ❑ Other: _____ ❑ Patient has signed HUMIRA Complete form	2	
❑ _____	_____	_____		
❑ _____	_____	_____		
❑ _____	_____	_____		

5 INJECTION TRAINING:

❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PRODUCT DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION:

Please Include Front and Back Copies of Pharmacy and Medical Card

8 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.