Cosentino's SPECIALTY CARE

OPHTHALMOLOGY SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

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: (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	

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to 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
	❑ 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
❑ HUMIRA®	❑ 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	
	All strengths and dosages listed are Humira® Citrate Free			
❑ _____	_____	_____		
❑ _____	_____	_____		
❑ _____	_____	_____		

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.