

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

**Ophthalmology Form**

**Patient information**

Patient: \_\_\_\_\_  Female  Male DOB: \_\_\_\_\_ Insurance plan: \_\_\_\_\_ Plan ID #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Home phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_ Caregiver: \_\_\_\_\_ Caregiver phone #: \_\_\_\_\_  
 Other medical conditions: \_\_\_\_\_ Allergies:  No  Yes: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lb  kg Date: \_\_\_\_\_

**Clinical information**

ICD-10 code: \_\_\_\_\_  
 If applicable, please provide each previous therapy and its dates:  
 Therapy: \_\_\_\_\_ Discontinuation reason: \_\_\_\_\_ Dates: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Prescription information** Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Dose	Route	Directions	Quantity	Refills
<input type="checkbox"/> Beovu	<input type="checkbox"/> 6 mg/0.05 mL PFS	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Byooviz	<input type="checkbox"/> 0.5 mg/0.05ml SDV	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Cimerli	<input type="checkbox"/> 0.3 mg/0.05mL SDV <input type="checkbox"/> 0.5 mg/0.05mL SDV	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Eylea	<input type="checkbox"/> 2 mg/0.05 mL SDV <input type="checkbox"/> 2 mg/0.05 mL PFS	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Iluvien	<input type="checkbox"/> 0.19 mg implant	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Lucentis	<input type="checkbox"/> 0.3 mg/0.05 mL PFS <input type="checkbox"/> 0.5 mg/0.05 mL PFS <input type="checkbox"/> 0.3 mg/0.05 mL SDV <input type="checkbox"/> 0.5 mg/0.05 mL SDV	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Ozurdex	<input type="checkbox"/> 0.7 mg implant	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Susvimo	<input type="checkbox"/> 100mg/ml SDV (Implant Refill)	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Syfovre	<input type="checkbox"/> 15 mg/0.1ml SDV	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Triesence	<input type="checkbox"/> 40 mg/mL SDV	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Vabysmo	<input type="checkbox"/> 6mg/0.05ml SDV	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Visudyne	<input type="checkbox"/> 15 mg SDV	IV	_____	_____	_____
<input type="checkbox"/> Yutiq	<input type="checkbox"/> 0.18 mg implant	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU	_____	_____	_____

**Prescriber and shipping information (please print)**

Prescriber: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Ship to:  Patient  Office  Other: \_\_\_\_\_  
 Office address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Office phone number: \_\_\_\_\_ Office fax number: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: \_\_\_\_\_  
 The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.