aleracare
advanced specialty pharmacy

Ophthalmic
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Clinical Assessment

ICD-10 CODES:

- ◯ H35.32 Neovascular (Wet) age-related Macular Degeneration
- ◯ H34.8190 Macular Edema Following Retinal Vein Occlusion
- ◯ E11.311 Diabetic Macular Edema
- ◯ E11.319 Diabetic Retinopathy
- ◯ H44.2A9 Myopic Choroidal Neovascularization
- ◯ Other: _____

History:

Prior Failed Therapies:

- ◯ _____
- ◯ _____
- ◯ _____
- ◯ _____
- ◯ _____

Medication	Dose	Directions for Use	Qty	Refills
◯ **LUCENTIS®** (Ranibizumab)				
◯ Lucentis 0.5mg (10mg/ml) PFS	◯ 0.5mg (0.05ml)	◯ Via intravitreal injection once a month		
◯ Lucentis 0.3mg (6mg/ml) PFS	◯ 0.3mg (0.05ml)	◯ Via intravitreal injection once a month		

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

_____ _____

Prescriber's Signature **Date**