

Optum Specialty Phone: 855-427-4682 Optum Specialty Fax: 877-342-4596

Ophthalmology Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

This form is not a valid prescription in Arizona

PATIENT INFORMATION		PRESCRIBER IN	PRESCRIBER INFORMATION			
Please complete the following or send patient demographic sheet		Prescriber's Name	Prescriber's Name			
Patient Name		_ DEA	DEA			
Address		_ NPI	NPI			
Address 2		Group/Hospital	Group/Hospital			
City, State, ZIP			Address			
Home Phone Alternate Phone		_ City, State, ZIP	City, State, ZIP			
DOB Last Four of SS# Gender			Fax			
Language Preference: English Spanish Other			Phone			
	TION (Must fax a copy of patient's insurance		d including both sides)			
Prior Authorization Reference numb						
		p process prescription) (Attach separate sheet ii	f needed)		
MEDICAL INFORMATION (Section must be completed to p. Diagnosis — Please include diagnosis name with ICD-10 code		Additional Information	Therapy: New Rea	_	Restart	
E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema		Weight	kg/lbs Height		cm/in	
		Allergies	Allergies			
H35.32 Exudative age-related m	acular degeneration	Lab Data	Lab Data			
H35.81 Retinal edema		Concomitant Medications	Concomitant Medications			
Other Diagnosis: ICD-10 Code _		l				
Description		_ Additional Comments	Additional Comments			
Date of Diagnosis		-				
PRESCRIPTION INFOR	MATION					
Medication	Dose/Strength	Directions	I	Quantity	Refills	
EYLEA® (aflibercept)	,					
EYLEA® (aflibercept) LUCENTIS® (ranibizumab)						
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LUCENTIS® (ranibizumab) BEOVU® (brolucizumab) Ship to: Office Other		Date	Needs by Dation process for my patient(s), and to sign and that this pharmacy determines that it is u	te		
LUCENTIS® (ranibizumab) BEOVU® (brolucizumab) Ship to: Office Other	y and its representatives to act as my authorized agent to secure covered prior authorization forms and the receipt and submission of patien	Date	Needs by Dation process for my patient(s), and to sign and that this pharmacy determines that it is u	te		
LUCENTIS® (ranibizumab) BEOVU® (brolucizumab) Ship to: Offfice Other *Prescriber Authorization: I authorize this pharmacy authorized agent, including the receipt of any require authorized agent, including the receipt of any require authorized sets pharmacy to forward this information Product Substitution permitted Prescriber's	v and its representatives to act as my authorized agent to secure covered prior authorization forms and the receipt and submission of patien and any related materials related to coverage of the product to anoth Dispense as Written	Date rage and initiate the insurance prior authorizat It lab values and other patient data. In the ever er pharmacy of the patient's choice or in the p Supervising Physician	Needs by Dat ion process for my patient(s), and to sign and that this pharmacy determines that it is u atient's insurer's provider network.	te		
LUCENTIS® (ranibizumab) BEOVU® (brolucizumab) Ship to: Office Other *Prescriber Authorization: I authorize this pharmacy authorized agent, including the receipt of any require authorize this pharmacy to forward this information Product Substitution permitted Prescriber's	v and its representatives to act as my authorized agent to secure covered prior authorization forms and the receipt and submission of patien and any related materials related to coverage of the product to anoth	Date rage and initiate the insurance prior authorizat It lab values and other patient data. In the ever er pharmacy of the patient's choice or in the p Supervising Physician	Needs by Dation process for my patient(s), and to sign and that this pharmacy determines that it is u	te		

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona.