HAWAII SPECIALTY™ PHARMACY

OPHTHALMOLOGY REFERRAL FORM

Please fax to Hawaii Specialty Pharmacy at 808-333-3682

Your HSP Contact:_____ and Tel: _____

PATIENT INFORMATION:	PHYSICIAN INFORMATION:
Patient Name:	Physician Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Alt. Phone:	Phone: Fax:
Email: SSN#	Office Email:
Date of Birth: Sex: ☐Male ☐Female	Key Off. Contact:
Weight: ____☐kgs ☐lbs Height: ____☐cm ☐ft BSA: ____	State LIC# NPI# DEA#

INSURANCE INFORMATION: ☐ **DEMOGRAPHIC SHEET** ☐ **UNIVERSAL CLAIM FORM** ☐ **INSURANCE CARDS** (front + back)

**Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)*

CLINICAL DIAGNOSIS: *Please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization*

Diagnosis / H35.32: ☐ Neovascular (Wet) AMD / _____ **H35.8190:** ☐ Macular Edema RVO / _____
E11.311: ☐ Diabetic Macular Edema (DME) / _____ **E11.319:** ☐ Diabetic Retinopathy / _____
H35.059: Myopic Choroidal Neovascularization (mCNV) ☐ _____ ☐ Other: _____

MEDICATIONS AND DIRECTIONS

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ **Avastin®**	☐ Avastin 100mg/4mL Single Dose Vial	Inject _____ intravitreally at MD office one every _____	28 day supply	
☐ **Eylea ®**	☐ Eylea 2mg/0.05mL Single Dose Vial	☐ Inject 2mg (0.05mL) intravitreally at MD office every 4 weeks for first 3 months followed by 2mg(0.05mL) intravitreally once every 8 weeks	84 day supply	
	☐ Eylea 2mg/0.05mL Single Dose Vial	☐ Inject 2mg (0.05mL) intravitreally at MD office once every 8 weeks	56 day supply	
☐ **Lucentis ®**	☐ Lucentis 0.5 mg/0.05 mL PFS	☐ 0.5 mg (0.05mL) inject intravitreally at MD office every 28 days	28 day supply	
	☐ Lucentis 0.3 mg/0.05 mL PFS	☐ 0.3 mg (0.05mL) inject intravitreally at MD office every 28 days	28 day supply	

☐ **Other:**

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

I authorize Hawaii Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5