OPHTHALMIC Referral Form

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ 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:** □ □ □ □ □ □

Drug Name	Dose/Strength	Directions	Quantity	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 month		

By signing this form, I authorize MedicoRX 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.

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Prescriber's signature (no stamps) if brand required check this ☐ DAW___ **Date**