LIFECARE PHARMACY

www.lifecarepharmacy.com

Ophthalmology Referral Form

Surescripts ID #:

Office #: 1-210-881-0890
Fax #: 1-210-569-6464

Referral Info

PATIENT INFORMATION

PATIENT NAME		SSN #:		DOB:	
ADDRESS:		CITY:	STATE:	ZIP:	
HOME PHONE:	CELL PHONE:	HEIGHT:	WEIGHT:	GENDER: MALE FEMALE	
Email ADDRESS:		DIAGNOSIS CODE:			

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

PRODUCT INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
○ Amikacin				
○ Bevacizumab				
○ Ceftazidime				
○ Dexamethasone				
○ Disodium Edetate (EDTA)				
○ Eylea				
○ Indocyanine Green(Sterile)				
○ Lohexol				
○ Lopamidol ○ Lopamidol-M				
○ Jetrea				
○ Mitomycin		Indication: _____		
○ Tissue Plasminogen Activator (TPA)				
○ Vancomycin				
○ Vision Blue				

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact/Faxed by:	Email:	
NPI#:	TAXID#:	Ship To: O Patient O MD 1ST Fill Only O MD All Orders
Prescriber Signature:		
O Dispense as written	Date	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

* We will let you know within 2 hours if your patient can be admitted pending insurance Qualification or non-admitted and triaged to another pharmacy

This prescription is valid only if transmitted by Facsimile machine by a licensed prescriber

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