

Anti-VEGF Questionnaire

PRE-REQUISITE FOR INTRAVITREAL INJECTION

This is a pre-requisite form provided upon request for intravitreal injection of Ranibizumab or Aflibercept, Anti-Vascular endothelial growth factor for diabetics and senile macular degeneration.

Kindly fill in all the requested information given below. This is a mandatory step in order to proceed further. Failure to provide information relevant for approval will delay the processing of the applicant request. The provider will be contacted in case further clarifications are required.

GENERAL INFORMATION

- Patient's Name: _____

New Established

- Patient's Card #: _____

- Age: Under 18 Above 18 years.

- Providers Name: _____

- Prescribing Physician Speciality: _____

- Diagnosis (ICD-10): _____

- Requested Drug: _____

- Date of last intravitreal injection: _____

Kindly attach the following (if applicable):

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Optical Coherence Tomography | <input type="checkbox"/> Current report | <input type="checkbox"/> Previous OCT |
| <input type="checkbox"/> Fundus Angiography/ Fluorescein Angiography | <input type="checkbox"/> Current | <input type="checkbox"/> Previous |
| <input type="checkbox"/> Report of previous administration of anti-VEGF in the past month. | | |

INITIAL REQUEST (new patient)

- Visual Acuity: _____
- IOP: _____
- Anterior Segment Examination:

- Dilated eye exam findings: (posterior segment examination)

- Optical Coherence Tomography (OCT) findings:

- Fundus Photo, Fluorescein angiography findings (if applicable):

REFILL REQUEST

Right Eye Left Eye Both

- Approximate number of injections:

ADDITIONAL COMMENTS:

Empty box for additional comments.