

Drug Pre-requisite Form- INTRAVITREAL INJECTION

This is a pre-requisite form provided upon request for intravitreal injection of Ranibizumab or Aflibercept, AntiVascular 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: _____	<input type="checkbox"/> New <input type="checkbox"/> Established
Patient's Card #: _____	
Age: <input type="checkbox"/> Under 18 <input type="checkbox"/> Above 18 years.	
Providers Name: _____	
Prescribing Physician Speciality: _____	
Diagnosis (ICD-I0): _____	
Requested Drug: _____	
Date of last intravitreal injection: _____	

Kindly attach the (following) (if applicable):

- Optical Coherence Tomography (current) report Previous OCT
- Fundus Angiography/ Fluorescein Angiography (current) Previous
- 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:
