



Fax the completed form to
(818) 236-2504

Questions? Call (818) 236-2500
Monday to Friday, 10 am to 6 pm

E-prescribing? Send to Foothill Remedy Drugs
6253 Foothill Blvd, Tujunga, CA 91042 · NPI 1134270135

Please send with this form: ☐ Insurance cards, front and back ☐ Recent labs ☐ Clinical notes ☐ Current medication list

1 Patient

Or attach a patient face sheet

Last name _____ First name _____ Date of birth _____

Sex ☐ F ☐ M ☐ X Height _____ Weight _____ ☐ kg ☐ lb Allergies ☐ None known _____

Address _____ City _____ State _____ ZIP _____

Cell phone _____ Other phone _____ Email _____

Preferred language ☐ English ☐ Armenian ☐ Farsi ☐ Russian ☐ Spanish ☐ Other _____

2 Insurance

Or attach copies of the cards, front and back

Primary plan _____ Member ID _____ Group # _____ Phone _____

Secondary plan _____ Member ID _____ Group # _____ Phone _____

3 Prescriber

Prescriber name _____ NPI _____ License # _____

Practice _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Office contact _____

Contact phone _____ Contact email _____

4 Clinical information

Please attach recent labs and notes

Diagnosis ☐ Wet AMD ☐ Diabetic macular edema ☐ Retinal vein occlusion ☐ Uveitis ☐ Dry eye ☐ Demodex blepharitis ☐ Other

ICD-10 code _____ Eye ☐ Right ☐ Left ☐ Both Visual acuity: right _____ Left _____

Next injection appointment _____ Injection interval _____ weeks Deliver by _____

Therapy status ☐ New start ☐ Continuing current therapy ☐ Switching from _____

Reason for switching _____

TB test ☐ Negative ☐ Positive Date _____ Hepatitis B screen ☐ Negative ☐ Positive ☐ Not done

Current medications ☐ List attached _____

5 Delivery

Needed by _____ Deliver to ☐ Patient's home ☐ Prescriber's office ☐ Patient will pick up at the pharmacy

Delivery is free within 25 miles of our Tujunga store.

Patient name _____ Date of birth _____

6 Prescription

Check each medication to fill. Directions and quantity can be changed.

☐ New start: also dispense the loading doses in each checked drug's label

Medication	Strength	Directions	Quantity	Refills
Retina injections, delivered to your office				
☐ Pavblu afibercept-ayyh	2 mg/0.05 mL	Inject 2 mg into the eye every ____ weeks	1 vial	_____
☐ Beovu brolucizumab-dbl	6 mg/0.05 mL	Inject 6 mg into the eye every ____ weeks	1 dose	_____
☐ Cimerli ranibizumab-eqrn	0.3 mg or 0.5 mg	Inject ____ mg into the eye every ____ weeks	1 vial	_____
Uveitis				
☐ Humira adalimumab	40 mg/0.4 mL pen	Inject 40 mg subcut every other week	2 pens	_____
☐ Adalimumab biosimilar the plan's preferred biosimilar	40 mg pen	Inject 40 mg subcut every other week	2 pens	_____
Dry eye and eyelids				
☐ Cyclosporine 0.05% Restasis or generic	single-use vials	1 drop in each eye twice daily, 12 hours apart	60 vials	_____
☐ Cequa cyclosporine 0.09%	single-use vials	1 drop in each eye twice daily, 12 hours apart	60 vials	_____
☐ Xiidra lifitegrast 5%	single-use vials	1 drop in each eye twice daily, 12 hours apart	60 vials	_____
☐ Miebo perfluorohexyloctane	3 mL bottle	1 drop in each eye 4 times daily	1 bottle	_____
☐ Xdemvy lotilaner 0.25%, for Demodex blepharitis	10 mL bottle	1 drop in each eye twice daily for 6 weeks	1 bottle	_____

Other medication (write in)

☐ _____

☐ _____

7 Prescriber signature

By signing, I confirm that this medication is medically necessary and that the information on this form is accurate to the best of my knowledge.

Prescriber signature _____ Date _____

☐ Do not substitute Prescriber initials _____ California law requires the prescriber to initial this box to prevent substitution.