ABD Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

UVEITIS ENROLLMENT FORM

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

PATIENT INFORMATION

Patient Name: Date of Birth: ☐ Male ☐ Female

Address: Phone: Alt Phone:

Height: | Weight: | Allergies :

DIAGNOSIS

☐ Primary Acute Anterior Uveitis (H20.0)
☐ Recurrent Acute Anterior Uveitis (H20.02)
☐ Chronic Anterior Uveitis (H20)
☐ Other:

Affected Eye(s)
☐ Left Eye ☐ Right Eye ☐ Both Eyes
Additional justification for drug:

CLINICAL INFORMATION

Treatment history:
☐ New start ☐ Restart ☐ Continuing therapy ☐ Drug change
Failed therapies:_______________________________

Date of TB test: ________________ **Results:** ☐ negative ☐ pending
Current therapy: _________________________
Stop before starting new therapy? ☐ Yes ☐ No
Withhold for how long before starting: ______________________

DRUG		DIRECTIONS	QTY	REF
☐ **HUMIRA** Citrate Free	**Pediatric Dosing:**	**Pediatric Use, ages 2 and over:**		
	☐ **Humira** 10 mg **PFS**	☐ **10 kg (22 lbs) to less than 15 kg (33 lbs):** Inject 1 PFS (10 mg) SQ every other week		
	☐ **Humira** 20 mg **PFS**	☐ **15 kg (33 lbs) to less than 30 kg (66 lbs)**: Inject 1 PFS (20 mg) SQ every other week		
	☐ **Humira** 40 mg **Pen** ☐ **Humira** 40 mg **PFS**	☐ **30 kg (66 lbs) and greater:** Inject 40 mg SQ every other week		
	Adult dosing:	**Adults**:		
	☐ Humira 80mg loading dose **Pen** Kit	☐ **Loading dose:** Inject 1 pen (80 mg) SQ on day 1, then 1 pen (40 mg) SQ on day 8, then 1 pen (40mg) every other week thereafter	1 kit	0
	☐ **Humira** 40 mg **Pen** ☐ **Humira** 40 mg **PFS**	☐ **Maintenance dose:** Inject 40 mg SQ every other week		

☐ Counsel patient with ABD@Home virtual video consultation service
☐ Patient is ready to start treatment, contact patient for delivery
☐ Ship all orders to office
☐ Ship first order to office, subsequent orders to patient

SIGNATURE		DATE:	
PHYSICIAN NAME:	DEA #:	NPI #:	STATE LICENSE #:
PRACTICE NAME:	ADDRESS:	CITY, STATE:	ZIP:
PHONE #:	FAX:	OFFICE CONTACT:	

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.
Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified