reliance|rx℠
45 Earhart Drive, Suite 110, Amherst, NY 14221

EYLEA/ LUCENTIS AUTHORIZATION AND REAUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name	First Name	Today's Date	Date Needed
Parent/Guardian		Prescriber	Hospital/Clinic
Home Phone Number ( )	Work Phone Number ( )	Phone Number ( )	Fax Number ( )
Home Address	City State Zip	Address	City State Zip
Ship To: ☐ Prescriber ☐ Patient's Home		Office Contact	Prescriber Speciality
Language Preference ☐ English ☐ Spanish ☐ Other			
Known Allergies:		Contact Preference ☐ Phone ☐ Fax ☐ Email: _____	
Weight _____ Lbs.	Height ____ Ft ____ In	Date of Birth ___ / ___ / ___ Sex ☐ M ☐ F	Special Instructions

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: _____

Name of Insured: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD 10 CODE: _____

□ Retinal Vein Occlusion □ Diabetic Macular Edema

□ Wet age-Related macular degeneration

□Other _____

Affected Eye: ☐ Right ☐ Left ☐ Both

Lucentis: Has patient tried and failed Eylea prior to this request?

☐ Yes ☐No

Does a contraindication to Eylea exist? ☐ Yes ☐ No

Medical History: _____

_____

_____

DRUG NAME

☐ **LUCENTIS** ☐**EYLEA** ☐**OTHER**

Dose: _____

Frequency: _____

Expected duration of therapy: _____