



**Phone: 1-888-899-7447**  
**Fax: 1-866-368-9808**

**CAP**  
**Ophthalmology**  
**Patient Order Form**

**PATIENT INFORMATION**

Patient Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies	<input type="checkbox"/> NKDA
Date of Birth	SSN#	Weight _____ <input type="checkbox"/> kg <input type="checkbox"/> lb BSA _____ m <sup>2</sup> Date		
Address		City	State	Zip
Phone # (Home)	(Work)	Email address (optional)		

**INSURANCE INFORMATION (PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS)**

Primary Insurance		Medicare ID
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

**DIAGNOSIS INFORMATION (Please specify primary and secondary diagnoses)**

Primary ICD-9	Secondary ICD-9
Is patient new to therapy? <input type="checkbox"/> yes <input type="checkbox"/> no Date of diagnosis	

**PRESCRIPTION INFORMATION**

<u>Medication</u>	<u>Dose</u>	<u>Directions/Frequency of Administration</u>	<u>Total # Doses</u>
<input type="checkbox"/> Visudyne®	6 mg/m <sup>2</sup> BSA	<input type="checkbox"/> _____ mg IV over 10 minutes (rate = 3ml/min)	
<input type="checkbox"/> Macugen®	0.3 mg	<input type="checkbox"/> Once every 6 weeks by intravitreal injection into affected eye(s) <input type="checkbox"/> _____	
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			

**DELIVERY INSTRUCTIONS**

<b>Order will be shipped to the address provided below. Physician must be registered with CAP at this location and this must be the site of administration.</b>	<b>Administration Date *</b>
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**PHYSICIAN CONTACT INFORMATION & AUTHORIZATION**

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address		City/State/Zip
DEA #	UPIN #	
CAP PIN #	NPI #	

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (required to process prescription – stamped signatures are not permissible)

R (12/28/06)

**If this order is needed in less than 48 hours please call 888-899-7447 to place order.**