Current as of 6/1/2013. This document may not be part of the latest approved REMS.
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OPHTHALMOLOGIC ASSESSMENT FORM

INSTRUCTIONS

1. **This form may be completed by either the prescriber or consultant ophthalmic professional. This form must be signed by the prescriber and faxed to SHARE for every patient at baseline (within 4 weeks of starting SABRIL).**
2. **For patients formally exempted from visual assessment due to blindness or irreversible neurological condition, subsequent forms are not required to be submitted.**
3. **For all other patients, follow-up assessment forms are required to be submitted at least every 90 days while the patient is taking SABRIL and approximately 3-6 months after discontinuation.**
4. **The diagnostic approach should be individualized according to each patient and/or clinical situation. Although attempts should be made to assess visual acuity and visual fields, no specific tests are required.**
5. **All fields must be completed.**

Completed forms should be faxed to the SHARE Call Center at 1-877-742-1002.

SECTION ONE: Patient Profile

Name (First, Middle, Last) ____________________ Sex: ❒ Male ❒ Female DOB ____________ (month/day/year)

Address ____________________ City ____________________ State _____ ZIP____________

Patient currently on SABRIL: ❒ YES ❒ NO

SECTION TWO: Consultant Ophthalmic Professional*

Was an ophthalmic professional consulted? ❒ YES ❒ NO

Ophthalmic Professional Name (First, Middle Initial, Last) ____________________ NPI #____________

Address ____________________ City ____________________ State _____ ZIP____________

Phone ____________________

I (ophthalmic professional's name, printed),____________________, attest that the vision assessment as indicated below was conducted.

Signature: ____________________ ***Date:***____________

**With expertise in visual field interpretation and the ability to perform dilated indirect ophthalmoscopy of the retina.*

SECTION THREE: Ophthalmologic Assessment

1. Was an ophthalmologic assessment conducted? ❒ YES ____________ (month/day/year) ❒ NO

If NO, for which reason was an ophthalmologic assessment not conducted?

❒ Patient is blind *(Checking this box exempts patient from follow-up assessments)*

❒ Patient's general neurological condition precludes the need for visual assessment

❒ This condition is reversible ❒ This condition is irreversible *(Checking this box exempts patient from follow-up assessments)*

❒ Patient's medical condition precludes safe visual assessment *(please explain)* ____________________

____

❒ This condition is reversible ❒ This condition is irreversible

❒ Other *(please explain)* ____________________

Assessment form continues on page 2

Assessment form continued from page 1 **Patient Name** (First, Middle, Last) ____________________

If assessment occurred more than 1 month after the due date, please indicate the reason:

- ❒ Patient's financial/reimbursement situation
- ❒ Transportation issues
- ❒ Scheduling conflicts
- ❒ Other *(please explain)* ____________________

2. Was a best-corrected visual acuity evaluation conducted? ❒ YES ❒ NO

If yes, please indicate the results: Left eye _______/________ Right eye _______/________

3. Were the visual fields assessed? ❒ YES ❒ NO

Was confrontational testing conducted? ❒ YES ❒ NO

Which method of visual field testing was used? ***(check all that apply)***

- ❒ Kinetic: Goldmann, V4e isopter
- ❒ Kinetic: automated (SSA-kinetic test from Humphrey or Octopus perimeter menu: III4e isopter)
- ❒ Static automated threshold perimetry (to at least 60°)
- ❒ Other ____________________

Was this the same technique as used for baseline? ❒ YES ❒ NO ❒ Unknown or N/A

Was the test deemed reliable? ❒ YES ❒ NO ❒ Unknown or N/A

Comment ____________________

Please indicate the results by providing the estimated visual field extent in:

Temporal field OD_________degrees from center Temporal field OS_________degrees from center

Nasal field OD_________degrees from center Nasal field OS_________degrees from center

4. Other types of testing performed ***(Check all that apply. No specific tests are required and this question may be left blank.)***

❒ None ❒ Indirect ophthalmoscopy/Fundoscopy ❒ OCT ❒ ERG ❒ Other____________________

SECTION FOUR: Prescriber Agreement and Signature

I (prescriber's name, printed),____________________, agree that I have received and reviewed the vision assessment results for my patient and will submit this form to the SHARE Call Center.

Signature: ____________________ ***Prescriber's NPI #:*** ____________________***Date:***________________

If formal perimetry or OCT was conducted, please attach a copy of the visual field recordings.

www.LundbeckSHARE.com

Fax to 1-877-742-1002

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