DELTADRUGS

# Dermatology S-Z

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 818.309.2884 • **FAX:** 818.309.1704 • www.deltadrugs.com

RESET FORM

## PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Secondary Phone #: _____

Patient SSN#: _____ Date of Birth: _____

Weight (lbs): _____ Height (in.): _____ Gender: ❑ Male ❑ Female

Allergies: _____

Primary Insurance: _____

ID#: _____ Phone #: _____

Secondary Insurance: _____

ID#: _____ Phone #: _____

**FAX COPY OF INSURANCE CARD (FRONT & BACK)**

## PHYSICIAN INFORMATION

Physician Name: _____

Contact: _____

NPI #: _____

Address: _____

_____

_____
City, State, Zip Code

Phone #: _____

Alt Phone #: _____

Fax #: _____

Email: _____

Ship Rx to: ❑ Physician's Office ❑ Patient's home

## CLINICAL INFORMATION

ICD-10 Diagnosis

- ❑ L40.0 Psoriasis vulgaris
- ❑ L40.8 Other psoriasis
- ❑ L40.9 Psoriasis, unspecified
- ❑ L40.5 Psoriatic arthritis
- ❑ L73.2 Hidradenitis suppurativa

Date of Diagnosis: _____ Date of negative TB test: _____ HBV: ❑ Yes ❑ No

BSA affected (%): _____ Affected areas: ❑ Head ❑ Neck ❑ Palms ❑ Soles ❑ Genitalia

Comorbidities: _____

Medication Reconciliation: _____

| Prior Treatment/Therapy (If Any) | Reason for Discontinuation | Start and End Date of Therapy |
|---|---|---|
| | | |
| | | |
| | | |

**FAX COPY OF ALL RELATED CLINICAL/LAB INFO**

| MEDICATION | DIRECTIONS | QTY | REFILLS |
|---|---|---|---|
| ❑ STELARA® USTEKINUMAB | ❑ Inject 45 mg subcutaneously on day 1 (≤100 kg)<br>❑ Inject 90 mg subcutaneously on day 1 (>100 kg) | ❑ 1x45 mg/0.5 mL PFS<br>❑ 1x90 mg/mL PFS | 0 |
| | ❑ Inject 45 mg SQ on day 29 and every 12 weeks after (≤100 kg)<br>❑ Inject 90 mg SQ on day 29 and every 12 weeks after (>100 kg) | | |
| | Patient eligible to self-administer medication? ❑ Yes ❑ No | | |
| ❑ TALTZ® IXEKIZUMAB | ❑ Weeks 0-2: Inject 160 mg (2x80 mg) SQ on week 0, & inject 80 mg SQ on week 2 | ❑ 3x80 mg/mL Autoinjectors | 0 |
| | ❑ Weeks 4-10: Inject 80 mg SQ on week 4, & every two weeks after through week 10 | ❑ 2x80 mg/mL Autoinjectors | 1 |
| | ❑ Weeks 12+: Inject 80 mg SQ on week 12, & every four weeks after | ❑ 1x80 mg/mL Autoinjector | |

Injection Training Provided By: ❑ Physician's Office ❑ Delta Drugs | ❑ Dispense As Written

Physician's Signature: _____ Date: _____

**I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.**