DELTADRUGS

Injectable Diabetic Medication

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

PATIENT INFORMATION

Patient Name: ______________________ Patient SSN#: ______________________

Address: ______________________
Address, City, State, Zip Code

Phone #: __________ 2nd Phone #: __________ Date of Birth: __________ Gender: ❑ Male ❑ Female

Weight (lbs): __________ Height (in.): __________ Allergies: __________

Primary Insurance: ______________________ | Secondary Insurance: ______________________

ID#: __________ Phone #: __________ | ID#: __________ Phone #: __________

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

ICD-10 Diagnosis

❑ E10.0 Diabetes Mellitis Type I

❑ E11.0 Diabetes Mellitis Type II

Comorbidities:

____

Medication Reconciliation:

____

Prior Medication History

❑ Tresiba ❑ Novolog ❑ Insulin N ❑ R ❑ Invokana ❑ Onglyza ❑ Actos

❑ Glipizide ❑ Humalog ❑ Glucophage ❑ Jardiance ❑ Glyburide ❑ Amaryl

Failed due to:

❑ Failure to treat ❑ Failure to control A1C ❑ Failure to control BG ❑ Hypoglycemia

❑ Nausea ❑ Vomiting ❑ Metallic taste in the mouth

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	STRENGTH/SIZE	DIRECTIONS	QTY	REFILLS
❑ BYDUREON® EXENATIDE	❑ 2 mg	❑ Inject 1 syringe once a week	❑ 4 syringes	
❑ BYETTA® EXENATIDE	❑ 5 mcg ❑ 10 mcg	❑ Inject 1 syringe once a day	❑ __________	
❑ TANZEUM® ALBIGLUTIDE	❑ 30 mg ❑ 50 mg	❑ Inject 1 syringe once a week	❑ 4 syringes	
❑ TRESIBA® INSULIN DEGLUDEC	❑ 200 u/mL ❑ 100 u/mL	❑ __________	❑ 4.5 mL	
❑ TRULICITY® DULAGLUTIDE	❑ 0.75 mg/0.5 mL ❑ 1.5 mg/0.5 mL	❑ __________	❑ __________	
❑ VICTOZA® LIRAGLUTIDE		❑ Inject 1 syringe once a day	❑ 2 pens ❑ 3 pens	
❑ PEN NEEDLES	❑ 31 gauge ❑ 32 gauge	❑ 4 mm ❑ 5 mm ❑ 6 mm		

Injection Training Provided By: ❑ Physician's Office ❑ Delta Drugs | Ship to: ❑ Physician's Office ❑ Patient's Home ❑ Other: __________

PHYSICIAN INFORMATION

Physician Name: __________ Contact: __________ NPI#: __________

Address: ______________________
Address, City, State, Zip Code

Phone #: __________ Fax#: __________ Email: __________

Physician's Signature: ______________________ Date: __________ ❑ Dispense As Written

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

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