DELTADRUGS

Dialysis Support Medications

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

RESET FORM

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

❑ D63.1 Chronic Kidney Disease ❑ N17.9 Acute Renal Failure

BUN: _____ Serum Creatinine: _____ Hemoglobin: _____ Hematocrit: _____

AST: _____ ALT: _____ Bilirubin: _____ Liver Dysfunction: ❑ Yes ❑ No

Type of Dialysis: ❑ Hemodialysis ❑ Peritoneal Dialysis ❑ Continuous Dialysis ❑ Intermittent Dialysis

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
ACTIVE VITAMIN D INTRAVENOUS				
❑ ZEMPLAR® PARICALCITOL				
❑ HECTOROL® DOXERCALCIFEROL				
ACTIVE VITAMIN D ORAL				
❑ ROCALTROL® CALCITRIOL				
❑ HECTOROL® DOXERCALCIFEROL				
❑ ZEMPLAR® PARICALCITOL				
VITAMINS FOR DIALYSIS				
❑ NEPHRO-VITE®				
❑ NEPHROCAPS®				
❑ NEPHROPLEX®				
CRAMPS				
❑ VITAMIN E				

Administered by: ❑ Physician ❑ Home Health RN ❑ SNF ❑ Dialysis Center | Ship to: ❑ Dialysis Center ❑ Patient's Home ❑ _____

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.