DELTADRUGS

Heart Failure

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

❑ I50.20 Unspecified systolic (congestive) heart failure
❑ I50.22 Chronic systolic (congestive) heart failure
❑ _____

Resting Heart Rate: _____ BPM In sinus rhythm? ❑ Yes ❑ No

Left Ventricular Ejection Fraction ❑ _____ % NYHA Class: ❑ II ❑ III ❑ IV

Prior Treatment History

Beta-blockers: ❑ Atenolol _____ mg ❑ Bisoprolol _____ mg
❑ Carvedilol _____ mg ❑ Metoprolol Succinate _____ mg
❑ Nadolol _____ mg ❑ Propranolol _____ mg
Stable at Maximum Tolerated Dose: ❑ Yes ❑ No
❑ Not on beta-blocker due to: ❑ intolerance ❑ contraindication

ACEs: ❑ Captopril ❑ Enalapril ❑ Lisinopril ❑ Perindopril ❑ Ramipril ❑ Trandolapril

ARBs: ❑ Benicar ❑ Candesartan ❑ Edarbi ❑ Irbesartan ❑ Losartan ❑ Micardis ❑ Telmisartan ❑ Valsartan

Comorbidities: _____

_____

Medication Reconciliation: _____

_____

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	STRENGTH	DIRECTIONS			QTY	REFILLS
❑ CORLANOR®	❑ 2.5 mg ❑ 5 mg ❑ 7.5 mg	❑ Twice daily by mouth			❑ 30 Day Supply	
❑ EDARBI	❑ 40 mg ❑ 80 mg	❑ One tablet by mouth daily			❑ 30 Day Supply	
❑ ENTRESTO® ❑ 24/26 mg* (sacubitril 24 mg & valsartan 26 mg) ❑ 49/51 mg* (sacubitril 49 mg & valsartan 51 mg) ❑ 97/103 mg* (sacubitril 97 mg & valsartan 103 mg) **dose based on current treatments*	If on ACEi	Patient taking >10 mg enalapril (or equivalent of another ACEi)	Stop ACEi 36 hours before starting ENTRESTO	❑ 49/51 mg twice daily	❑ 60 Day Supply	
		Patient taking ≤10 mg enalapril (or equivalent of another ACEi)		❑ 24/26 mg twice daily ❑ 49/51 mg twice daily after 2-4 weeks		
	If on ARB	Patient taking >160 mg valsartan (or equivalent of another ARB)		❑ 49/51 mg twice daily		
		Patient taking ≤160 mg valsartan (or equivalent of another ARB)		❑ 24/26 mg twice daily ❑ 49/51 mg twice daily after 2-4 weeks		
	Not on ACEi or ARB					
	Severe renal impairment	❑ 24/26 mg twice daily ❑ 49/51 mg twice daily after 2-4 weeks ❑ 97/103 mg twice daily after another 2-4 weeks				
	Moderate hepatic impairment					
	Avoid use of ENTRESTO w/ an ARB (ENTRESTO contains the angiotensin II receptor blocker valsartan)					

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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