DELTADRUGS

Ophthalmology

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

Allergies: _____

Primary Insurance: _____ | Secondary Insurance: _____

ID#: _____ Phone #: _____ | ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
❑ BESIVANCE®				
❑ BROMSITE™	❑ 0.075%	❑ Instill one drop into OS / OD / OU BID	❑ 5 mL	
❑ DUREZOL®				
❑ ILEVRO™				
❑ LASTACAFT®				
❑ LOTEMAX® GEL				
❑ LUMIGAN®				
❑ NEVANAC®				
❑ PAZEO®				
❑ PROLENSA®				
❑ RESTASIS®	❑ 0.05%	❑ Instill one drop in each eye twice daily* **Single use vial, do not reuse*	❑ 30 vials ❑ 60 vials	
❑ RESTASIS MULTIDOSE®	❑ 0.05%	❑ Instill one drop in each eye twice daily	❑ 5.5 mL	
❑ SIMBRINZA®				
❑ TRAVATAN Z®				
❑ VEXOL®				
❑ VIGAMOX®				
❑ XIIDRA™	❑ 5%	❑ Instill one drop in each eye twice daily* **Single use vial, do not reuse*	❑ 60 vials	
❑ ZIOPTAN®				
❑ ZYMAXID®				

Ship to: ❑ Physician's Office ❑ Patient's Home | ❑ Dispense As Written

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

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.