DELTADRUGS

# Rheumatology 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

❑ M06.9 Rheumatoid Arthritis
❑ M08.0 Juvenile Idiopathic Arthritis
❑ L40.59 Psoriatic Arthritis
❑ L40.54 Psoriatic Juvenile Arthritis
❑ M45.9 Ankylosing Spondylitis

Date of Diagnosis: _____ Date of negative TB test: _____

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 |
|---|---|---|---|---|
| ❑ SIMPONI® | | ❑ Inject 50 mg subcutaneously once monthly | 1 box (1x50 mg/0.5mL)<br>❑ SmartJet™ ❑ PFS | |
| ❑ SIMPONI® ARIA™ | Starter | ❑ Infuse 2mg/kg over 30 minutes at weeks 0 | _____ vials (50 mg/ 4 ml vial) | |
| | Maint. | ❑ Infuse 2 mg/kg over 30 minutes at week 4 and every 8 weeks after | _____ vials (50 mg/ 4 ml vial) | |
| ❑ STELARA® | Starter | ❑ Inject 45 mg/0.5 mL SQ on day 1 (≤100 kg/220 lbs)<br>❑ Inject 90 mg/0.5 mL SQ on day 1 (≤100 kg/220 lbs) | ❑ 1 PFS | |
| | Maint. | ❑ Inject 45 mg/0.5 mL SQ on day 29 an every 12 weeks thereafter (≤100 kg/220 lbs)<br>❑ Inject 90 mg/0.5 mL SQ on day 29 and every 12 weeks thereafter (≤100 kg/220 lbs) | | |
| ❑ XELJANZ® | | ❑ Take 5 mg by mouth twice daily ❑ _____ | ❑ 60 tablets ❑ _____ | |
| ❑ XELJANZ® XR | | ❑ Take 11 mg by mouth twice daily | ❑ 30 tablets | |
| ❑ ZURAMPIC® | | ❑ | ❑ 30 tablets | |

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.**