DELTADRUGS

Urology

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

❑ _____

Comorbidities:

_____

Medication Reconciliation:

_____

Serum Creatinine: _____ Hemoglobin/Hematocrit: _____

Renal Dysfunction: ❑ Yes ❑ No Liver Dysfunction: ❑ Yes ❑ No

HbA1C level/Date: _____ Serum PSA level/Date: _____

Serum Testosterone level/Date: _____ Date of Orchietomy: _____

Prior Treatment/Therapy (If Any)	Reason for Discontinuation	Start and End Date of Therapy

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
❑ CASODEX	❑ 50 mg	❑ Take 1 tablet daily		
❑ LUPRON DEPOT				
❑ XYGEVA®				
❑ XTANDI®	❑ 160 mg	❑ Take four 40 mg capsules orally once daily		
❑ ZYTIGA®	❑ 1000 mg	❑ Take four 250 mg capsules orally once daily w/o food		
❑ PREDNISONE	❑ 5 mg	❑ Take twice daily w/food		

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.