DELTADRUGS

Specialty Pain Management

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

❑ M79.1 Acute, Painful Musculoskeletal Condition

Date of diagnosis: _____ Years w/ disease: _____

Therapy start date: _____ Therapy stop date: _____

Previous use of muscle spasm medications: ❑ Cyclobenzaprine ❑ Methocarbamol ❑ Soma

Failed due to: ❑ Ineffective ❑ Extreme drowsiness ❑ Extreme dizziness

Previous use of NSAIDs: ❑ Meloxicam ❑ Ibuprofen ❑ Naproxen ❑ Diclofenac

Failed due to: ❑ Ulcer of stomach ❑ Irritation of stomach

Previous use of topical pain medications: ❑ Diclofenac 1% Gel ❑ Voltaren gel

Failed due to: ❑ Irritation ❑ Failure to treat

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
❑ AMRIX®	❑ 15 mg ❑ 30 mg	❑ Take 1 capsule by mouth once daily for 2 weeks then as needed		
❑ RAYOS®	❑ 5 mg	❑ TPO Q Day (Prednisone)		
❑ IBUPROFEN	❑ 600 mg			
❑ LIDODERM		❑ Apply one patch topically once a day (12 hours on / 12 hours off)		
❑ SKELAXIN®	❑ 800 mg	❑ Take 1 tablet by mouth 4 times a day		
❑ HORIZANT®	❑ 300 mg ❑ 600 mg			

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.