DELTADRUGS

Chronic Idiopathic Constipation

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 818.309.2884 • **FAX:** 818.309.1704 • www.deltadrugs.com

PATIENT INFORMATION

Patient Name: ______________________ Patient SSN#: ______________________

Address: ____
Address, City, State, Zip Code

Phone #: ____________ 2nd Phone #: ____________ Date of Birth: ____________ Gender: ❑ Male ❑ Female

Weight (lbs): ________ Height (in.): ________ Allergies: ______________________

Primary Insurance: ______________________ | Secondary Insurance: ______________________

ID#: ____________ Phone #: ____________ | ID#: ____________ Phone #: ____________

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

ICD-10 Diagnosis

❑ K59.04 Chronic Idiopathic Constipation

Comorbidities:

____

Medication Reconciliation:

____

Prior Medication History

❑ Lactulose ❑ Fleet enema ❑ Docusate ❑ Sennakot ❑ Metamucil ❑ Fiber

❑ Bisacodyl ❑ MOM ❑ Linzess ❑ Amitiza ❑ Miralax

Failed due to:

❑ Failed to treat constipation ❑ Nausea ❑ Vomiting ❑ Severe diarrhea ❑ Severe gas

❑ Gastric reflux

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
❑ AMITIZA	❑ 24 mcg (capsules) ❑ 8 mcg (capsules)	❑ Take 1 capsule by mouth twice daily	❑ 60 capsules	
❑ LINZESS®	❑ 290 mcg (capsules) ❑ 145 mcg (capsules)	❑ Take 1 capsule by mouth once daily	❑ 30 capsules	
❑ TRULANCE™	❑ 3 mg	❑ Take 1 tablet by mouth daily	❑ 30 tablets	

Injection Training Provided By: ❑ Physician's Office ❑ Delta Drugs | 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.

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