DELTADRUGS

Dermatology H-S

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

- ❑ L40.0 Psoriasis vulgaris
- ❑ L40.8 Other psoriasis
- ❑ L40.9 Psoriasis, unspecified
- ❑ L40.5 Psoriatic arthritis
- ❑ L73.2 Hidradenitis suppurativa

Date of Diagnosis: _____ Date of negative TB test: _____ HBV: ❑ Yes ❑ No

BSA affected (%): _____ Affected areas: ❑ Head ❑ Neck ❑ Palms ❑ Soles ❑ Genitalia

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
❑ HUMIRA® ADALIMUMAB	❑ Inject 80 mg SQ on day 1, 40 mg on day 8, and 40 mg every 2 weeks after ❑ Inject 160 mg SQ on day 1, 80 mg on day 15 ❑ _____	❑ 4x40 mg/0.8 mL ❑ 6x40 mg/0.8 mL ❑ PFS ❑ Pens	0
	❑ Inject 40 mg subcutaneously every 2 weeks ❑ Inject 40 mg subcutaneously on day 29 and every week after	❑ 2x40 mg/0.8 mL ❑ 4x40 mg/0.8 mL ❑ PFS ❑ Pens	
❑ OTEZLA® APREMILAST	❑ Take as directed on package instructions ❑ Take 30 mg twice daily by mouth ❑ _____	❑ 28 day starter pack	0
		❑ 55 tablets ❑ 60x30mg tablets ❑ _____	
❑ SIMPONI® GOLIMUMAB	❑ Inject 50 mg SQ once a month	❑ 1x150 mg/mL ❑ 2x150 mg/mL ❑ PFS ❑ Sensoready® Pen	

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.