DELTADRUGS

Dermatology 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

- ❑ 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
❑ STELARA® USTEKINUMAB	❑ Inject 45 mg subcutaneously on day 1 (≤100 kg) ❑ Inject 90 mg subcutaneously on day 1 (>100 kg)	❑ 1x45 mg/0.5 mL PFS ❑ 1x90 mg/mL PFS	0
	❑ Inject 45 mg SQ on day 29 and every 12 weeks after (≤100 kg) ❑ Inject 90 mg SQ on day 29 and every 12 weeks after (>100 kg)		
	Patient eligible to self-administer medication? ❑ Yes ❑ No		
❑ TALTZ® IXEKIZUMAB	❑ Weeks 0-2: Inject 160 mg (2x80 mg) SQ on week 0, & inject 80 mg SQ on week 2	❑ 3x80 mg/mL Autoinjectors	0
	❑ Weeks 4-10: Inject 80 mg SQ on week 4, & every two weeks after through week 10	❑ 2x80 mg/mL Autoinjectors	1
	❑ Weeks 12+: Inject 80 mg SQ on week 12, & every four weeks after	❑ 1x80 mg/mL Autoinjector	

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.