

PATIENT INFORMATION	PHYSICIAN INFORMATION
Patient Name: _____	Physician Name: _____
Address: _____	Contact: _____
City, State, Zip: _____	NPI #: _____
Phone #: _____ Secondary Phone #: _____	Address: _____
Patient SSN#: _____ Date of Birth: _____	_____
Weight (lbs): _____ Height (in.): _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	City, State, Zip Code
Allergies: _____	_____
Primary Insurance: _____	Phone #: _____
ID#: _____ Phone #: _____	Alt Phone #: _____
Secondary Insurance: _____	Fax #: _____
ID#: _____ Phone #: _____	Email: _____
<b>FAX COPY OF INSURANCE CARD (FRONT &amp; BACK)</b>	Ship Rx to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's home

CLINICAL INFORMATION	
ICD-10 Diagnosis <input type="checkbox"/> E10.0 Diabetes Mellitus Type I <input type="checkbox"/> E11.0 Diabetes Mellitus Type II Comorbidities: _____ Medication Reconciliation: _____	Prior Medication History <input type="checkbox"/> Tresiba <input type="checkbox"/> Novolog <input type="checkbox"/> Insulin N <input type="checkbox"/> R <input type="checkbox"/> Invokana <input type="checkbox"/> Onglyza <input type="checkbox"/> Actos <input type="checkbox"/> Glipizide <input type="checkbox"/> Humalog <input type="checkbox"/> Glucophage <input type="checkbox"/> Jardiance <input type="checkbox"/> Glyburide <input type="checkbox"/> Amaryl Failed due to: <input type="checkbox"/> Failure to treat <input type="checkbox"/> Failure to control A1C <input type="checkbox"/> Failure to control BG <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Metallic taste in the mouth <div style="text-align: center;"><b>FAX COPY OF ALL RELATED CLINICAL/LAB INFO</b></div>

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> FARXIGA® DAPAGLIFLOZIN	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> GLYXAMBI® EMPAGLIFLOZIN/LINAGLIPTIN	<input type="checkbox"/> 10/5 mg tablets <input type="checkbox"/> 25/5 mg tablets	<input type="checkbox"/> TPO QDay	<input type="checkbox"/> 30	
<input type="checkbox"/> INVOKAMET® CANAGLIFLOZIN/METFORMIN HCl	<input type="checkbox"/> 50/500 mg tablets <input type="checkbox"/> 50/1000 mg tablets <input type="checkbox"/> 150/500 mg tablets <input type="checkbox"/> 150/1000 mg tablets	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> INVOKANA® CANAGLIFLOZIN	<input type="checkbox"/> 100 mg tablets <input type="checkbox"/> 300 mg tablets	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> JANUMET® SITAGLIPTIN/METFORMIN HCl	<input type="checkbox"/> 50/500 mg tablets <input type="checkbox"/> 50/1000 mg tablets	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> JANUVIA® SITAGLIPTIN	<input type="checkbox"/> 25 mg tablets <input type="checkbox"/> 50 mg tablets <input type="checkbox"/> 100 mg tablets	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> JARDIANCE® EMPAGLIFLOZIN	<input type="checkbox"/> 10 mg tablets <input type="checkbox"/> 25 mg tablets	<input type="checkbox"/> TPO QDay	<input type="checkbox"/> 30	
<input type="checkbox"/> JENTADUETO® LINAGLIPTIN/METFORMIN HCl	<input type="checkbox"/> 2.5/1000 mg tablets	<input type="checkbox"/> TPO BID	<input type="checkbox"/> 60	
<input type="checkbox"/> KAZANO ALOGLIPTIN/METFORMIN HCl	<input type="checkbox"/> 12.5/500 mg tablets <input type="checkbox"/> 12.5/1000 mg tablets	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> NESINA ALOGLIPTIN	<input type="checkbox"/> 25 mg tablets	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> ONGLYZA® SAXAGLIPTIN	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> OSENI ALOGLIPTIN/PIOGLITAZONE	<input type="checkbox"/> 25/15 mg tablets <input type="checkbox"/> 25/30 mg tablets <input type="checkbox"/> 25/45 mg tablets	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> SYNJARDY® EMPAGLIFLOZIN/METAFORMIN HCl	<input type="checkbox"/> 5/500 mg tablets <input type="checkbox"/> 5/1000 mg tablets <input type="checkbox"/> 12.5/500 mg tablets <input type="checkbox"/> 12.5/1000 mg tablets	<input type="checkbox"/> TPO QDay	<input type="checkbox"/> 30	
<input type="checkbox"/> TRADJENTA® LINAGLIPTIN	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/> TPO QDay	<input type="checkbox"/> 30	

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.**