

PATIENT INFORMATION	
Patient Name: _____ Patient SSN#: _____	
Address: _____ <small style="text-align: center;">Address, City, State, Zip Code</small>	
Phone #: _____ 2 nd Phone #: _____ Date of Birth: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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	
<input type="checkbox"/> D63.1 Chronic Kidney Disease-Induced Hyperphosphatemia <input type="checkbox"/> N17.9 Acute Renal Failure-Induced Hyperphosphatemia	
BUN: _____ Serum Creatinine: _____ Phosphorus Levels: _____ Hematocrit: _____	
AST: _____ ALT: _____ Bilirubin: _____ Liver Dysfunction: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Dialysis: <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Continuous Dialysis <input type="checkbox"/> Intermittent Dialysis	
FAX COPY OF ALL RELATED CLINICAL/LAB INFO	

PHOSPHORUS BINDERS				
MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> PHOSLO®				
<input type="checkbox"/> RENAGEL® SEVELAMER				
<input type="checkbox"/> RENVELA® SEVELAMER CARBONATE				
<input type="checkbox"/> FOSRENOL® IANTHANUM CARBONATE				
ITCHING DURING DIALYSIS				
<input type="checkbox"/> BENADRYL® DIPHENHYDRAMINE				
<input type="checkbox"/> ATARAX®				
<input type="checkbox"/> VISTARIL® HYDROXYZINE				
<input type="checkbox"/> ZYRTEC® CETIRIZINE				
Administered by: <input type="checkbox"/> Physician <input type="checkbox"/> Home Health RN <input type="checkbox"/> SNF <input type="checkbox"/> Dialysis Center Ship to: <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Patient's Home <input type="checkbox"/> _____				

PHYSICIAN INFORMATION	
Physician Name: _____ Contact: _____ NPI#: _____	
Address: _____ <small style="text-align: center;">Address, City, State, Zip Code</small>	
Phone #: _____ Fax#: _____ Email: _____	
Physician's Signature: _____ Date: _____ <input type="checkbox"/> Dispense As Written	
I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.	