

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: _____	Phone #: _____
Primary Insurance: _____	Alt Phone #: _____
ID#: _____ Phone #: _____	Fax #: _____
Secondary Insurance: _____	Email: _____
ID#: _____ Phone #: _____	Ship Rx to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's home
FAX COPY OF INSURANCE CARD (FRONT & BACK)	

CLINICAL INFORMATION		
ICD-10 Diagnosis <input type="checkbox"/> M10.0 Idiopathic Gout <input type="checkbox"/> M10.1 Lead-induced Gout <input type="checkbox"/> M10.2 Drug-induced Gout <input type="checkbox"/> M10.3 Gout due to renal impairment <input type="checkbox"/> M10.4 Secondary Gout <input type="checkbox"/> M10.9 Gout, unspecified	Patient is not concurrently on: <input type="checkbox"/> Azathioprine <input type="checkbox"/> Mercaptopurine Uric Acid level: _____ Date: _____ 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	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> ULORIC	<input type="checkbox"/> 40 mg <input type="checkbox"/> 80 mg	<input type="checkbox"/> Take one tablet by mouth daily	<input type="checkbox"/> 30 tablets	
<input type="checkbox"/> COLCRYS	<input type="checkbox"/> 0.6 mg	<input type="checkbox"/> Take one tablet by mouth twice daily <input type="checkbox"/> Take one tablet by mouth once daily	<input type="checkbox"/> 60 tablets <input type="checkbox"/> 30 tablets	
	<p><i>Colcris</i> is contraindicated in patients with renal or hepatic impairment who are currently prescribed P-gp inhibitors or strong inhibitors of CYP3A4. In these patients, life-threatening and fatal colchicine toxicity has been reported with colchicine taken in therapeutic doses. Dose adjustments of <i>Colcris</i> may be required when co-administered with P-gp or CYP3A4 inhibitors in patients with normal renal and hepatic function.</p>			

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.