DELTADRUGS

Infant Enteral Nutrition

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 800.700.6401 • **FAX:** 866.700.6401 • www.deltadrugs.com

RESET FORM

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Address: _____

City, State, Zip: _____

Phone #: _____ 2nd Phone #: _____ Email: _____

Allergies: _____

Primary Insurance: _____ ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

Formula Needed: _____ Quantity: _____

Daily Sig: _____

Diagnosis: _____

Birth Weight (lbs): _____ Birth Height (in.): _____ Current Weight (lbs): _____ Current Height (in.): _____

Rechallenge Date: _____ Results: _____

Weeks of Gestation: _____ Formula Tried: _____

Is patient Immunocompromised?: ❑ Yes ❑ No If premie date of actual corrected age: _____ Intake: ❑ Oral ❑ G-Tube

JUSTIFY NEED OR CONTINUATION

_____

_____

_____

_____

❑ I have reviewed my patient's medical records and the items requested above. I verify that this patient's medical condition requires the products and the usage quantities are medically necessary for the patient. I will maintain a copy of this prescription in the patient's file to meet carrier documentation requirements.

Authorization Period: _____ To: _____ Refill: _____

FAX COPY OF ALL RELATED CLINICAL NOTES AND GROWTH CHARTS

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____

Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

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.

KINDLY ATTACH CLINICAL NOTES AND GROWTH CHARTS AND FAX TO 866.700.6401