

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	
Allergies: _____	
Primary Insurance: _____ Secondary Insurance: _____	
ID#: _____ Phone #: _____ ID#: _____ Phone #: _____	
FAX COPY OF INSURANCE CARD (FRONT & BACK)	

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> RESTASIS®	<input type="checkbox"/> 0.05%	<input type="checkbox"/> Instill one drop in each eye twice daily* <i>*Single use vial, do not reuse</i>	<input type="checkbox"/> 30 vials <input type="checkbox"/> 60 vials	
<input type="checkbox"/> RESTASIS MULTIDOSE®	<input type="checkbox"/> 0.05%	<input type="checkbox"/> Instill one drop in each eye twice daily	<input type="checkbox"/> 5.5 mL	
<input type="checkbox"/> XIIDRA™	<input type="checkbox"/> 5%	<input type="checkbox"/> Instill one drop in each eye twice daily* <i>*Single use vial, do not reuse</i>	<input type="checkbox"/> 60 vials	
Ship to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Dispense As Written				

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: _____	
I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.	