DELTADRUGS

Glaucoma

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 818.309.2884 • **FAX:** 818.309.1704 • www.deltadrugs.com

RESET FORM

PATIENT INFORMATION

Patient Name: _____ Patient SSN#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ 2nd Phone #: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Allergies: _____

Primary Insurance: _____ | Secondary Insurance: _____

ID#: _____ Phone #: _____ | ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

ICD-10 Diagnosis
❑ H40. ____ Glaucoma

Failed: ❑ Latanoprost ❑ Brimonidine 0.2% ❑ Trusopt 0.1% ❑ Dorzolamide

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
❑ ALPHAGAN® P	❑ 0.1%	Instill ____ drop(s) into ____ eye(s) ❑ QD ❑ BID	❑ 10 mL	
❑ LUMIGAN®	❑ 0.1%	Instill ____ drop(s) into ____ eye(s) ❑ QD ❑ BID	❑ 7.5 mL	
❑ COMBIGAN®	❑ 0.2%/0.5%	Instill ____ drop(s) into ____ eye(s) ❑ QD ❑ BID	❑ 15 mL	

Ship to: ❑ Physician's Office ❑ Patient's Home

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

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.