

PATIENT INFORMATION	
Patient Name: _____ Patient SSN#: _____	
Address: _____ <small style="text-align: center;">Address, City, State, Zip Code</small>	
Phone #: _____ 2 <sup>nd</sup> Phone #: _____ Date of Birth: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Allergies: _____	
Primary Insurance: _____ Secondary Insurance: _____	
ID#: _____ Phone #: _____ ID#: _____ Phone #: _____	
<b>FAX COPY OF INSURANCE CARD (FRONT &amp; BACK)</b>	

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> BESIVANCE®				
<input type="checkbox"/> BROMSITE™	<input type="checkbox"/> 0.075%	<input type="checkbox"/> Instill one drop into OS / OD / OU BID	<input type="checkbox"/> 5 mL	
<input type="checkbox"/> DUREZOL®				
<input type="checkbox"/> ILEVRO™				
<input type="checkbox"/> LASTACFT®				
<input type="checkbox"/> LOTEMAX® GEL				
<input type="checkbox"/> LUMIGAN®				
<input type="checkbox"/> NEVANAC®				
<input type="checkbox"/> PAZEO®				
<input type="checkbox"/> PROLENSA®				
<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"/> SIMBRINZA®				
<input type="checkbox"/> TRAVATAN Z®				
<input type="checkbox"/> VEXOL®				
<input type="checkbox"/> VIGAMOX®				
<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	
<input type="checkbox"/> ZIOPTAN®				
<input type="checkbox"/> ZYMAXID®				

Ship to:  Physician's Office  Patient's Home |  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.**