DELTADRUGS

Postherpetic Neuralgia

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

PATIENT INFORMATION

Patient Name: ______________________ Patient SSN#: ______________________

Address: ____
Address, City, State, Zip Code

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

Weight (lbs): ____________ Height (in.): ____________ Allergies: ____________

Primary Insurance: ______________________ | Secondary Insurance: ______________________

ID#: ____________ Phone #: ____________ | ID#: ____________ Phone #: ____________

FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

ICD-10 Diagnosis
❑ B02.2 Postherpetic Neuralgia

Date of diagnosis: ____________ Years w/ disease: ____________

Therapy start date: ____________ Therapy stop date: ____________

Previous use of muscle spasm medications: ❑ Cyclobenzaprine ❑ Methocarbamol ❑ Soma
Failed due to: ❑ Ineffective ❑ Extreme drowsiness ❑ Extreme dizziness

Previous use of NSAIDs: ❑ Meloxicam ❑ Ibuprofen ❑ Naproxen ❑ Diclofenac
Failed due to: ❑ Ulcer of stomach ❑ Irritation of stomach

Previous use of topical pain medications: ❑ Diclofenac 1% Gel ❑ Voltaren gel
Failed due to: ❑ Irritation ❑ Failure to treat

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
❑ HORIZANT®	❑ 300 mg ❑ 600 mg	❑ Take 1 tablet by mouth once daily before dinner ❑ Take 1 tablet by mouth twice daily before a meal		
❑ LIDODERM	❑ 5%	❑ Apply one patch topically once a day (12 hours on / 12 hours off)		

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.

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