DELTADRUGS

Rheumatology A-E

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

RESET FORM

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Secondary Phone #: _____

Patient SSN#: _____ Date of Birth: _____

Weight (lbs): _____ Height (in.): _____ Gender: ❑ Male ❑ Female

Allergies: _____

Primary Insurance: _____

ID#: _____ Phone #: _____

Secondary Insurance: _____

ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

PHYSICIAN INFORMATION

Physician Name: _____

Contact: _____

NPI #: _____

Address: _____

_____

_____
City, State, Zip Code

Phone #: _____

Alt Phone #: _____

Fax #: _____

Email: _____

Ship Rx to: ❑ Physician's Office ❑ Patient's home

CLINICAL INFORMATION

ICD-10 Diagnosis

❑ M06.9 Rheumatoid Arthritis
❑ M08.0 Juvenile Idiopathic Arthritis
❑ L40.59 Psoriatic Arthritis
❑ L40.54 Psoriatic Juvenile Arthritis
❑ M45.9 Ankylosing Spondylitis

Date of Diagnosis: _____ Date of negative TB test: _____

Comorbidities: _____

Medication Reconciliation: _____

_____

Prior Treatment/Therapy (If Any)	Reason for Discontinuation	Start and End Date of Therapy

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	DIRECTIONS	QTY	REFILLS
❑ ACTEMRA®	❑ Inject 162 mg subcutaneously every other week (<100 kg) ❑ Inject 162 mg subcutaneously every week (≤100 kg)	❑ 2 PFS ❑ 4 PFS	
❑ CIMZIA®	Starter: ❑ Inject 400 mg subcutaneously on weeks #1, 2, 4	1 Carton (2x200 mg): ❑ PFS ❑ Vials	
	Maintenance: ❑ Inject 400 mg subcutaneously every 4 weeks ❑ Inject 200 mg subcutaneously every 2 weeks		
❑ COSENTYX®	To order Cosentyx® please see the Novartis service request form at *cosentyxhcp.com/get-your-patients-started* Please choose '*Delta Drugs*' as the preferred specialty pharmacy to ensure medication is sent to Delta Drugs.		
❑ ENBREL®	❑ Inject 50 mg subcutaneously every week ❑ _____	❑ 1 Carton (4x50mg/mL) ❑ _____ ❑ PFS ❑ Vials ❑ SureClick®	

Injection Training Provided By: ❑ Physician's Office ❑ Delta Drugs | ❑ Dispense As Written

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.