

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
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	
<input type="checkbox"/> D63.1 Chronic Kidney Disease <input type="checkbox"/> N17.9 Acute Renal Failure	
BUN: _____	Serum Creatinine: _____
Hemoglobin: _____	Hematocrit: _____
AST: _____	ALT: _____
Bilirubin: _____	Liver Dysfunction: <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Dialysis: <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Continuous Dialysis <input type="checkbox"/> Intermittent Dialysis	
FAX COPY OF ALL RELATED CLINICAL/LAB INFO	

ACTIVE VITAMIN D INTRAVENOUS				
MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> ZEMPLAR® PARICALCITOL				
<input type="checkbox"/> HECTOROL® DOXERCALCIFEROL				
ACTIVE VITAMIN D ORAL				
<input type="checkbox"/> ROCALTROL® CALCITRIOL				
<input type="checkbox"/> HECTOROL® DOXERCALCIFEROL				
<input type="checkbox"/> ZEMPLAR® PARICALCITOL				
VITAMINS FOR DIALYSIS				
<input type="checkbox"/> NEPHRO-VITE®				
<input type="checkbox"/> NEPHROCAPS®				
<input type="checkbox"/> NEPHROPLEX®				
CRAMPS				
<input type="checkbox"/> VITAMIN E				
Administered by: <input type="checkbox"/> Physician <input type="checkbox"/> Home Health RN <input type="checkbox"/> SNF <input type="checkbox"/> Dialysis Center Ship to: <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Patient's Home <input type="checkbox"/> _____				

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: _____	<input type="checkbox"/> Dispense As Written
I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.		