

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"/> K59.09 Opioid-Induced Constipation Comorbidities: _____ Medication Reconciliation: _____	Prior Medication History <input type="checkbox"/> Lactulose <input type="checkbox"/> Fleet enema <input type="checkbox"/> Docusate <input type="checkbox"/> Sennakot <input type="checkbox"/> Metamucil <input type="checkbox"/> Fiber <input type="checkbox"/> Bisacodyl <input type="checkbox"/> MOM <input type="checkbox"/> Linzess <input type="checkbox"/> Amitiza <input type="checkbox"/> Miralax Failed due to: <input type="checkbox"/> Failed to treat constipation <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Severe diarrhea <input type="checkbox"/> Severe gas <input type="checkbox"/> Gastric reflux <p style="text-align: center;">FAX COPY OF ALL RELATED CLINICAL/LAB INFO</p>

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="checkbox"/> AMITIZA	<input type="checkbox"/> 24 mcg (capsules) <input type="checkbox"/> 8 mcg (capsules)	<input type="checkbox"/> Take 1 capsule by mouth twice daily	<input type="checkbox"/> 30 capsules	
<input type="checkbox"/> LINZESS®	<input type="checkbox"/> 290 mcg (capsules) <input type="checkbox"/> 145 mcg (capsules)	<input type="checkbox"/> Take 1 capsule by mouth once daily	<input type="checkbox"/> 30 capsules	
<input type="checkbox"/> MOVANTIK®	<input type="checkbox"/> 12.5 mg <input type="checkbox"/> 25 mg	<input type="checkbox"/> Take 1 tablet by mouth once daily	<input type="checkbox"/> 30	
<input type="checkbox"/> RELISTOR®	<input type="checkbox"/> 8 mg <input type="checkbox"/> 12 mg	<input type="checkbox"/> Inject SQ once daily	<input type="checkbox"/> 1 box	

Injection Training Provided By: Physician's Office Delta Drugs | 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.	