DELTADRUGS

Dry Eye

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

RESET FORM

PATIENT INFORMATION

Patient Name: _____ Patient SSN#: _____

Address: _____
Address, City, State, Zip Code

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

Allergies: _____

Primary Insurance: _____ | Secondary Insurance: _____

ID#: _____ Phone #: _____ | ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
❑ RESTASIS®	❑ 0.05%	❑ Instill one drop in each eye twice daily* **Single use vial, do not reuse*	❑ 30 vials ❑ 60 vials	
❑ RESTASIS MULTIDOSE®	❑ 0.05%	❑ Instill one drop in each eye twice daily	❑ 5.5 mL	
❑ XIIDRA™	❑ 5%	❑ Instill one drop in each eye twice daily* **Single use vial, do not reuse*	❑ 60 vials	

Ship to: ❑ Physician's Office ❑ Patient's Home | ❑ Dispense As Written

PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

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.