



Phone: 1-888-315-3395  
Fax: 1-800-546-2172



Attn: \_\_\_\_\_

Today's Date: \_\_\_\_\_  
Date Shipment Needed: \_\_\_\_\_  
Ship To:  Patient  Physician  
Nurse Instruction Needed?  Yes  No  
Agency: \_\_\_\_\_  
Permission to contact pt:  Yes  No  
\* All the supplies including syringes and needles will be dispensed if needed.

## Hepatitis Authorization Form

### General Information

Patient Name: _____	Physician Name: _____
Address: _____	Practice Name/Hospital: _____
City: _____ State: _____ Zip: _____	Address: _____
Home Phone: _____	City: _____ State: _____ Zip: _____
Work Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Soc. Sec #: _____ - _____ - _____ Date of Birth: _____	State Lic #: _____ DEA #: _____
Allergies: _____	NPI #: _____
Weight: _____ Height: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Nurse/Key Office Contact: _____

### Insurance Information

Primary Insurance: _____	Cardholder Name: _____	Secondary Insurance: _____
Employer: _____	ID#: _____	ID#: _____ Group#: _____
Phone: _____	Group#: _____	Phone: _____

### Statement of Medical Necessity

Primary Diagnosis: \_\_\_\_\_ Allergies: \_\_\_\_\_ RNA/Date: \_\_\_\_\_  
 ICD 9  070.54 Hepatitis C (Chronic)  Other ICD 9: \_\_\_\_\_ Viral Load: \_\_\_\_\_  
 Genotype: 1 2 3 4 Other: \_\_\_\_\_ Co Infected:  Yes  No  Naive  Relapser  Non-Responder

### Prescription Information

<b>Pegasys®</b> <input type="checkbox"/> Axiom PFS 180mcg/1ml <input type="checkbox"/> Roche Kit (180mcg/0.5ml) <input type="checkbox"/> 180mcg/ml SQ Weekly <input type="checkbox"/> Other _____ Qty _____ Refill x _____ Months	<b>Infergen®</b> <input type="checkbox"/> 9mcg Q day <input type="checkbox"/> 15mcg Q day <input type="checkbox"/> 9mcg TIW for _____ weeks <input type="checkbox"/> 15mcg TIW for _____ weeks <input type="checkbox"/> Other _____ Qty _____ Refill x _____ Months <small>* Axiom's ready to use syringes are used if not specified.</small>	<b>Peg-Intron®</b> <input type="checkbox"/> RediPen PAK 4 <input type="checkbox"/> Vial <input type="checkbox"/> <40 kg 50 mcg/0.5ml 0.5mL SQ QWK <input type="checkbox"/> 40-50 kg 80 mcg/0.5ml 0.4mL SQ QWK <input type="checkbox"/> 51-60 kg 80 mcg/0.5ml 0.5mL SQ QWK <input type="checkbox"/> 61-75 kg 120mcg/0.5ml 0.4mL SQ QWK <input type="checkbox"/> 76-85 kg 120mcg/0.5ml 0.5mL SQ QWK <input type="checkbox"/> >85 kg 150 mcg/0.5ml 0.5mL SQ QWK Qty _____ Refill x _____ Months
<b>RibaPak™ (ribavirin)</b> <input type="checkbox"/> 400/400 #56 (400 mg AM & 400 mg PM) <input type="checkbox"/> 400/600 #56 (600 mg AM & 400 mg PM) <input type="checkbox"/> 600/600 #56 (600 mg AM & 600 mg PM) <input type="checkbox"/> Other day supply: _____ Refill x _____	<b>Ribavirin</b> <input type="checkbox"/> 800mg/day <input type="checkbox"/> 1000mg/day <input type="checkbox"/> 1200mg/day <input type="checkbox"/> Other: _____ Refill x _____	<b>Neupogen®</b> <input type="checkbox"/> SQ QW <input type="checkbox"/> SQ BIW <input type="checkbox"/> 150mcg/0.5ml <input type="checkbox"/> 300mcg/1ml <input type="checkbox"/> 480mcg/1.6ml <input type="checkbox"/> Other _____ Qty _____ Refill x _____ Months <small>* Axiom's ready to use syringes are used if not specified.</small>
<b>Procrit®</b> <input type="checkbox"/> SQ QW <input type="checkbox"/> SQ BIW <input type="checkbox"/> 10,000 IU <input type="checkbox"/> 20,000 IU <input type="checkbox"/> 40,000 IU <input type="checkbox"/> Other _____ Qty _____ Refill x _____ Months <small>* Axiom's ready to use syringes are used if not specified.</small>		<b>Other Meds:</b> _____ Qty: _____ Refill x _____ Months Sig as directed: _____ <small>Generic substitution is mandated unless practitioner writes in the words "NO SUBSTITUTION"</small>

\*If you would like brand name, please write Medically Necessary.  
Please note that Axiom will dispense our formulary product unless otherwise specified.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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