



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



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

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

## Rheumatology 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: _____ Employer: _____ Phone: _____	Cardholder Name: _____ ID#: _____ Group#: _____	Secondary Insurance: _____ ID#: _____ Group#: _____ Phone: _____
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### Statement of Medical Necessity

Primary Diagnosis:  Rheumatoid Arthritis (714.0)  Psoriatic Arthritis (696.0)  Polyarticular Juvenile Rheumatoid Arthritis (714.30)  
 Osteoporosis (733.0)  Osteoarthritis (715.0)  Ankylosing Spondylitis (720.0)  
 Other: \_\_\_\_\_ (ICD 9 Code: \_\_\_\_\_)

### Prescription Information

<input type="checkbox"/> <b>Enbrel</b> <sup>®</sup> <input type="checkbox"/> 25 mg vials <input type="checkbox"/> 50mg/ml Sureclick Pen <input type="checkbox"/> 50 mg/ml PFS <input type="checkbox"/> Inject 25mg SQ TWICE a week <input type="checkbox"/> Inject 50mg SQ ONCE a week <input type="checkbox"/> Inject 50mg SQ TWICE a week x 2 months, then q week. <input type="checkbox"/> Other: _____ Qty: 1 month Refill x _____ MO	<b>Rituxan</b> (MD's office infusion) 1000mg IV infusion as directed on: <input type="checkbox"/> day 1 & day 15 (will dispense available vial size) Qty _____ Refill x _____ Months												
<input type="checkbox"/> <b>Humira</b> <sup>®</sup> <input type="checkbox"/> PEN 40 mg <input type="checkbox"/> PFS 40 mg <input type="checkbox"/> PEN 20 mg (PEDIATRIC) <input type="checkbox"/> Inject 40mg SQ ONCE a week <input type="checkbox"/> Inject 40mg SQ EVERY 2 WEEKS Qty: 1 month Refill x _____ MO	<b>Boniva</b> <input type="checkbox"/> 3mg/3ml PFS - 3mg IV over 15 to 30 seconds Q 3 months <i>(to be administered quarterly by a health care professional)</i> <input type="checkbox"/> 150mg tab po Q month Qty _____ Refill x _____ Months												
<input type="checkbox"/> <b>Kineret</b> 100 mg SQ QD Qty: 1 month Refill x _____ MO	<table border="1"> <thead> <tr> <th>Body Weight</th> <th>Dose</th> <th>Vials/dose</th> </tr> </thead> <tbody> <tr> <td>&lt;60 kg</td> <td>500 mg</td> <td>2</td> </tr> <tr> <td>60 - 100 kg</td> <td>750 mg</td> <td>3</td> </tr> <tr> <td>&gt;100 kg</td> <td>1000 mg</td> <td>4</td> </tr> </tbody> </table>	Body Weight	Dose	Vials/dose	<60 kg	500 mg	2	60 - 100 kg	750 mg	3	>100 kg	1000 mg	4
Body Weight		Dose	Vials/dose										
<60 kg	500 mg	2											
60 - 100 kg	750 mg	3											
>100 kg	1000 mg	4											
<input type="checkbox"/> <b>Forteo</b> 20 mcg SQ QD Qty: 1 PEN Refill x _____ MO	<b>Orencia</b> 250mg vial ( <i>dosage based on patient's weight (kg)</i> ) SIG: <input type="checkbox"/> Infuse at 0, 2, 4 weeks, then every 4 weeks. <input type="checkbox"/> Every 4 weeks Dispense: _____ doses Refill x _____ Months												
<input type="checkbox"/> <b>Remicade</b> Disp: 1 mo <input type="checkbox"/> 3mg/kg IV at wk 0, 2, & 6 wks, then Q8wks <input type="checkbox"/> 5mg/kg IV at wk 0, 2, & 6 wks, then Q8wks <input type="checkbox"/> Other: _____ Qty _____ Refill x _____ Months	<b>Other Medications:</b> _____ <input type="checkbox"/> Dose: _____ Sig: _____ Qty _____ Refill x _____ Months												
<input type="checkbox"/> <b>Boniva</b> <input type="checkbox"/> 3mg/3ml PFS - 3mg IV over 15 to 30 seconds Q 3 months <i>(to be administered quarterly by a health care professional)</i> <input type="checkbox"/> 150mg tab po Q month Qty _____ Refill x _____ Months													

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

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

**IMPORTANT NOTICE:** This transmission may contain confidential health information that is legally protected. As you are obligated to maintain it in a safe and confidential manner, unauthorized re-disclosure or a failure to maintain the confidentiality of the information contained herein could subject you to penalties under state and federal law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination or copying of this communication is strictly prohibited.