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

Exhibit S

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: ☐ Male ☐ 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

Pegasys®

☐ Axium PFS 180mcg/1ml
☐ Roche Kit (180mcg/0.5ml)
☐ 180mcg/ml SQ Weekly
☐ Other ______________________

Qty __________Refill x _______ Months

Infergen®

☐ 9mcg Q day
☐ 15mcg Q day
☐ 9mcg TIW for _____weeks
☐ 15mcg TIW for _____weeks
☐ Other ______________________

Qty __________Refill x _______ Months
* Axium's ready to use syringes are used if not specified.

Peg-Intron® ☐ **RediPen PAK 4** ☐ **Vial**

☐ **<40 kg**	50 mcg/0.5ml	0.5mL SQ QWK
☐ 40-50 kg	80 mcg/0.5ml	0.4mL SQ QWK
☐ 51-60 kg	80 mcg/0.5ml	0.5mL SQ QWK
☐ 61-75 kg	120mcg/0.5ml	0.4mL SQ QWK
☐ 76-85 kg	120mcg/0.5ml	0.5mL SQ QWK
☐ **>85 kg**	150 mcg/0.5ml	0.5mL SQ QWK

Qty __________Refill x _______ Months

RibaPak™ (ribavirin)

☐ 400/400 #56 (400 mg AM & 400 mg PM)
☐ 400/600 #56 (600 mg AM & 400 mg PM)
☐ 600/600 #56 (600 mg AM & 600 mg PM)
☐ Other day supply:________________
Refill x ______________________

Ribavirin

☐ 800mg/day
☐ 1000mg/day
☐ 1200mg/day
☐ Other:______________________
Refill x ______________________

Neupogen® ☐ SQ QW ☐ SQ BIW

☐ 150mcg/0.5ml
☐ 300mcg/1ml
☐ 480mcg/1.6ml
☐ Other ____________

Qty __________Refill x _______ Months
* Axium's ready to use syringes are used if not specified.

Procrit® ☐ SQ QW ☐ SQ BIW

☐ 10,000 IU ☐ 20,000 IU ☐ 40,000 IU
☐ Other ______________________
Qty __________Refill x _______ Months
* Axium's ready to use syringes are used if not specified.

Other Meds: ______________________

Qty: _________ Refill x _________ Months

Sig as directed: ____________________
Generic substitution is mandated unless practitioner writes in the words "NO SUBSTITUTION"

*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:** ____________________

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Rev. 10/13/08