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.

GENERIC RX AND STOCK REPLACEMENT AUTHORIZATION FORM

General Information

Patient	Physician
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	Cardholder	Secondary
Primary Insurance: ______________	Cardholder Name: ______________	Secondary Insurance: ____________
Employer: ______________________	ID#: __________________________	ID#: ________ Group#: ________
Phone: ________________________	Group#: _______________________	Phone: ______________________

Statement of Medical Necessity

Diagnosis	Code
Primary Diagnosis: ______________________________	ICD 9 Code: ______________________________

Prescription Information

Drug to be administered from (on): ____________ **Or** was administered on: __________and to be replaced to physician's office

R$_x$

*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. 07/10/07