



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.

Dermatology Authorization Form

General Information

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

Primary Diagnosis: _____ _____	ICD 9 Code: _____
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Insurance Information

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

Humira Pen <input type="checkbox"/> Pen <input type="checkbox"/> Pre-filled syringe <input type="checkbox"/> Humira Pen - Psoriasis Starter Pack: Inject 80mg (2 Pens) SQ on day 1; inject 40mg (1 Pen) SQ on day 8, then 40mg SQ every other week thereafter <input type="checkbox"/> Humira 40mg SQ every other week <input type="checkbox"/> Humira 40mg SQ every week <input type="checkbox"/> Other: _____ Qty: <u>1 month</u> Refill x _____ Months	R _x
Remicade _____ Weight <input type="checkbox"/> 5mg/kg IV at wk 0, 2, & 6 wks, then Q 8wks <input type="checkbox"/> 5mg/kg IV Q 8wks <input type="checkbox"/> Other: _____ Qty: <u>1 month</u> Refill x _____ Months	
Enbrel® <input type="checkbox"/> 50mg/ml SQ twice a week x 3 months, then weekly <input type="checkbox"/> 50mg/ml SQ q weekly #4 <input type="checkbox"/> Other: _____ Qty: <u>1 month</u> 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:** _____

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