



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.

Multiple Sclerosis 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: _____	ICD 9 Code: _____
_____	_____

Prescription Information

Avonex <input type="checkbox"/> 30mcg PFS IM injection qwk <input type="checkbox"/> 30mcg vials and dilute IM qwk <input type="checkbox"/> Other: _____ Qty: _____ Refill x _____	Rebif Titration Schedule <input type="checkbox"/> Rebif Titration Kit Rebif Maintenance <input type="checkbox"/> 44mcg PFS SQ tiw <input type="checkbox"/> Other: _____ Qty: _____ Refill x _____	Betaseron Titration Schedule <input type="checkbox"/> 0.0625mg SQ qod x 2 weeks <input type="checkbox"/> 0.125mg SQ qod x 2 weeks <input type="checkbox"/> 0.187mg SQ qod x 2 weeks <input type="checkbox"/> 0.25mg SQ qod <input type="checkbox"/> Other: _____ Qty: _____ Refill x _____
Copaxone 20mg <input type="checkbox"/> 20mg SQ qd <input type="checkbox"/> Other: _____ Qty: _____ Refill x _____	IVlg Brand: _____ <input type="checkbox"/> Dose: _____ <input type="checkbox"/> Other: _____ Sig: _____ Qty: _____ Refill x _____ Months: _____	
Other Medications Other: _____ 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: _____

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