



# AmeriHealth DIRECT SHIP INJECTABLE REQUEST FORM

For AmeriHealth members

Fax to: (215) 761- 9165

## Patient Information

Today's Date: \_\_\_\_\_ Member \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Member ID # \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Deliver Product to  Physician's office  Member's Home  Authorization Only [FLEX Series]

Pick up at retail Pharmacy (if applicable)

## Physician Information

Physician's Name (please print): \_\_\_\_\_

Office Contact: \_\_\_\_\_ Office Contact Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_

## Prescribed Injectable Request

Rx Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Date: \_\_\_\_\_

Sig: \_\_\_\_\_

Dispense Quantity: \_\_\_\_\_ Refills\*: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD 9 Code: \_\_\_\_\_

Phys. License #: \_\_\_\_\_ DEA #: \_\_\_\_\_

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

Substitution Permissible  Dispense As Written

Please use drug specific form if the request is for Botox, Myobloc, Synagis, Forteo, Growth Hormone, Amevive, Raptiva, Enbrel, Humira, Kineret, or Viscosupplementation (i.e. Synvisc, Euflexxa, etc.).

## For Internal Use Only

INFO Doc #: \_\_\_\_\_ Date Rec: \_\_\_\_\_ Pharmacy : Standard RX  Select RX

LOB: \_\_\_\_\_ Billing Code: \_\_\_\_\_ Vendor: \_\_\_\_\_ Medical  Medical Continuation hist.

Authorization #: \_\_\_\_\_ From: to \_\_\_\_\_ New Member

**A new form is not needed for each refill. Refills will be coordinated by the Injectable distributor.\***