



AmeriHealth Future Scripts Direct Ship Specialty Pharmacy Program

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.*