



## FutureScripts<sup>®</sup> Direct Ship Specialty Pharmacy Vaccine Program For AmeriHealth Members

Fax to: 215-761-9165

### Patient information

Today's date: \_\_\_\_\_ Date needed: \_\_\_\_\_  
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  
 Is vaccine being administered by physician?  Yes  No  
 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

Vaccine drug name: \_\_\_\_\_ Strength: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Dispense quantity: \_\_\_\_\_ Refills: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ ICD-9 code: \_\_\_\_\_  
Phys. license #: \_\_\_\_\_ DEA #: \_\_\_\_\_  
Physician signature: \_\_\_\_\_  
Substitution permissible  Dispense as written

### 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: