AmeriHealth.

FutureScripts® 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:** ☐

November 2009