Future Scripts Direct Ship Specialty Pharmacy Program
For AmeriHealth members

Fax to: (215) 761- 9165 or EMAIL: FSS_Standard_Medicare@catalystrx.com

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**

❒ **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.*