FutureScripts® Direct Ship Specialty Pharmacy Vaccine Program

For AmeriHealth New Jersey Members

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 telephone #:
Address:		
City:	State:	Zip:
Office telephone #:	Office fax #:	

PRESCRIBED INJECTABLE REQUEST

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

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: ☐

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