



**Future Scripts Direct Ship Specialty Pharmacy Program  
For Personal Choice and Keystone Health Plan East 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.\***