Independence Blue Cross

DIRECT SHIP INJECTABLE REQUEST FORM

For Personal Choice® and Keystone Health Plan East members

Fax to: (215) 761- 9165

Patient Information

Today's Date: _____ **Date Needed:** _____

Member Name: _____

Address: _____ **Carrier:** _____

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]**

Physician Information

Physician's Name (please print): _____

Office Contact:_____ **Office Contact Phone#:** _____

Address:_____

City: _____ **State:**_____ **Zip:** _____

Office Phone #: _____ **Office Fax #:** _____

Prescribed Drug / Statement of Medical Necessity

Rx Drug Name: _____ **Strength:** _____ **Date:** _____

Sig:_____

Dispense Quantity: _____ **Refills*:** _____

Diagnosis: _____ **ICD 9 Code:** _____

Comments or Pertinent Medical History: _____

Phys. License #: _____ **DEA #:** _____

Physician Signature: _____ _____

Substitution Permissible **Dispense As Written**

Please use drug specific form if the request is for Botox, Myobloc, Synagis or Growth Hormone.

For Internal Use Only

INFO Doc #:		**Date Rec:**	**Cov: Y N**
LOB:	**Billing Code:**	**Vendor:**	
Authorization #:		**From:**	**to**

***A new form is not needed for each refill. Refills will be coordinated by the Injectable distributor.**

Provider Communications