



FutureScripts Direct Ship Specialty Pharmacy Program

Fax to: (888) 671-5285

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: _____
 Physician's NPI# _____
 Phys. License #: _____ DEA #: _____
 Physician Signature: _____
 Substitu _____ tion Permissible _____ Dispen _____ se 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.*