Patient Enrollment Form

Referral Form Checklist

- ☐ Please complete the Referral form in its entirety.
- ☐ Include a copy of the **front & back** of the patient's insurance card.
- ☐ Include a recent copy of the patient's clinical notes to aid in the completion of the Prior Authorization form(s).
- ☐ Verify that the Doctor/Prescriber has signed the Referral Form.
- ☐ Fax all information to: **877-892-4007**

When you refer a patient to DirectRx, you can expect us to provide the following benefits:

- Immediate confirmation of receipt of your patient referral
- Status updates
- Thorough and timely processing of the patient's information and prescription, and a complete benefit investigation
- Assistance with prior authorization forms
- Communication with the patient to:
    - Inform them of receipt of their doctor's prescription by DirectRx
    - Explain the prior authorization process, if applicable
    - Notify of out-of-pocket costs
    - Obtain permission and assist in enrollment of copay assistance programs or completing funding applications when needed
- Pharmacist counseling for your patient with 24 hour on-call assistance availability

If you have any questions, please feel free to call DirectRx at 855-362-3397

DirectRx PHARMACY
830 Kirts Blvd, Ste 300 ● Troy, MI 48084
Phone: 855-362-3397 ● Fax: 877-892-4007

DirectRx PHARMACY

Crohn's & Ulcerative Colitis Referral Form

830 KIRTS BLVD, STE 300 • TROY, MI 48084
855.362.3397 • Fax: 877.892.4007
FOR MORE INFORMATION/REFERRAL FORMS VISIT WWW.DIRECTRX.COM

Patient Information ☐ New Rx ☐ Refill

Name | Date of Birth | Home Phone Number | Other Phone Number

Address | City | State | Zip

Patient SS# | ☐ Allergies | ☐ No Known Allergies

Drug Delivery Info

Date Shipment Needed: **Ship to:** ☐ Patient ☐ Clinic

Insurance Info [Fax a copy of the patient's insurance card (both sides.)]

Doctor/Prescriber Info [NPI # is mandatory.]

Name: | Office Contact :

Address: | City: | State: | Zip:

NPI # | Phone # | Fax #

Statement of Medical Necessity ** Please FAX recent clinical notes, tests, with the prescription to expedite the Prior Authorization.

Patient Weight: ☐ lbs. ☐ kg | TB/PPD Test given Date:

ICD10 Code:

Other reasons for treatment (complete or attach medical history)

No response to previous treatment: | Contraindications to other treatments:

Side effects: | Other:

Medication	Strength	Sig	Qty	Refills
☐ **Cimzia®** (certolizumab pegol) *Crohn's Disease Indication	☐ 200mg/mL Starter Kit	☐ Inject 400mg on day 1 then repeat dose 2 and 4 weeks after initial dose.		
	☐ 200mg/mL Vial ☐ 200mg/mL Prefilled Syringes	☐ Inject 400mg every 4 weeks		
☐ **Humira®** (adalimumab) *Crohn's Disease and Ulcerative Colitis Indication	☐ 40mg/0.8mL Crohn's Disease Starter Package Pen Kit ☐ 40mg/0.8mL Prefilled Pen Kit ☐ 40mg/0.8mL Prefilled Syringe Kit	☐ Initial: Inject 160mg on day 1, then 80mg on day 15, then 40mg every other week ☐ Maintenance: Inject 40mg SQ every other week.		
☐ **Simponi®** (golimumab) *Ulcerative Colitis Indication	☐ Smartject 100mg/mL Prefilled ☐ Syringes 100mg/mL	☐ Initial: Inject 200mg SQ at week 1, then 100mg at week 2, then start maintenance at week 6 ☐ Maintenance: Inject 100mg every 4 weeks starting at week 6		
☐ Other:				

Print Save

Doctor/Prescriber Signature | Date