

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



830 Kirks Blvd, Ste 300 • Troy, MI 48084
Phone: 855-362-3397 • Fax: 877-892-4007

Patient Information			
<input type="checkbox"/> New Rx		<input type="checkbox"/> Refill	
Name	Date of Birth	Home Phone Number	Other Phone Number
Address		City	State Zip
Patient SS#	<input type="checkbox"/> Allergies		<input type="checkbox"/> No Known Allergies

Drug Delivery Info	
Date Shipment Needed:	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> 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: <input type="checkbox"/> lbs. <input type="checkbox"/> 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
<input type="checkbox"/> Cimzia® (certolizumab pegol) * Crohn's Disease Indication	<input type="checkbox"/> 200mg/mL Starter Kit	<input type="checkbox"/> Inject 400mg on day 1 then repeat dose 2 and 4 weeks after initial dose.		
	<input type="checkbox"/> 200mg/mL Vial			
	<input type="checkbox"/> 200mg/mL Prefilled Syringes	<input type="checkbox"/> Inject 400mg every 4 weeks		
<input type="checkbox"/> Humira® (adalimumab) * Crohn's Disease and Ulcerative Colitis Indication	<input type="checkbox"/> 40mg/0.8mL Crohn's Disease Starter Package Pen Kit	<input type="checkbox"/> Initial: Inject 160mg on day 1, then 80mg on day 15, then 40mg every other week		
	<input type="checkbox"/> 40mg/0.8mL Prefilled Pen Kit	<input type="checkbox"/> Maintenance: Inject 40mg SQ every other week.		
	<input type="checkbox"/> 40mg/0.8mL Prefilled Syringe Kit			
<input type="checkbox"/> Simponi® (golimumab) †Ulcerative Colitis Indication	<input type="checkbox"/> Smartject 100mg/mL Prefilled	<input type="checkbox"/> Initial: Inject 200mg SQ at week 1, then 100mg at week 2, then start maintenance at week 6		
	<input type="checkbox"/> Syringes 100mg/mL	<input type="checkbox"/> Maintenance: Inject 100mg every 4 weeks starting at week 6		
<input type="checkbox"/> Other:				

Doctor/Prescriber Signature

Date

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan. **IMPORTANT CONFIDENTIALLY NOTICE:** This and any documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity name above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the content of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.