Samsca (tolvaptan)
Patient Enrollment Form

Referral Form Checklist

- ☐ Please complete the Samsca 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 the DirectRx Samsca phone line at

877-HYPONA+ *or* 877-497-6620

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

DirectRx PHARMACY

Samsca Referral Form

830 KIRTS BLVD STE 300 • TROY MI 48084
877-497-6620 (877-HYPONA+) • 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
Alternate Contact on Patients Behalf
Contact Phone
Gender Male ☐ Female ☐

Drug Delivery Info

Date Shipment Needed:
Ship to: ☐ Patient ☐ Clinic

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

Prescriber and Hospital Information [NPI # is mandatory]

Hospital Contact Person:
Hospital Name:
Prescriber Name:
City:
State:
Zip:
Address:
Phone #
Fax #
NPI#

Statement of Medical Necessity

ICD-10 Diagnosis code(s): **Please check all that apply

☐ E87.1 Hypo-osmolality and Hyponatremia ☐ E22.2 SIADH ☐ Other:

Inpatient Treatment Initiation Date:
Anticipated Discharge Date:

Has the patient been admitted or readmitted to the hospital in the last 30 to 90 days? Yes ☐ No ☐
Has the patient failed on other therapies? (e.g. fluid restriction or high dose diuretics) Yes ☐ No ☐
Based on the patient's history, is patient at risk for hospital readmission in the next 30 days? Yes ☐ No ☐
Serum Sodium prior to Samsca initiation: mEq/L
Total quantity dispensed since hospital admission:
Will patient receive a dose of Samsca on discharge date? Yes ☐ No ☐

Medication	Dose/Strength	Sig	Qty	Refills
☐ Samsca® (tolvaptan)	☐ 15mg ☐ 30mg			

Date

Doctor/Prescriber Signature

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan.
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