

#### **Referral Form Checklist**

#### To ensure the best possible insurance coverage, please provide:

- Completed and signed prescription referral form
- A copy of patient's insurance card and demographic information
- Copy of patient's most recent clinical notes



**Complete** referral form checklist and **provide required insurance and clinicals**.

Fax to: 877-892-4007

**Required:** Sending this documentation will ensure all insurance requirements are met



Send e-Scripts to: GabeCare DirectRx d/b/a DirectRx Pharmacy 830 Kirts Blvd. Suite 300 Troy, MI 48084 NPI: 1194725705

*Tip:* DirectRx can be found via a general pharmacy search by zip-code (48084)

Please remind the patient that DirectRx will be contacting them to schedule their medication delivery.

#### (P) 855-362-3397

Compassionate Connections. Successful Outcomes. Healthy, Happy Patients.

www.directrx.com



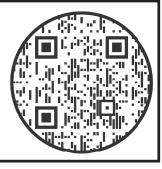
## Your prescription will be processed by DirectRx Pharmacy.

Here is what you can expect next:

- A personalized Welcome Call
- Complete review of your insurance
- Free and convenient delivery
- On-going care and support

A member of our team will be contacting you shortly.

Please scan the QR Code to add DirectRx's phone number, (855) 362-3397, to your contact list.



### (855) 362 - 3397 I info@directrx.com

**Compassionate** Connections. **Successful** Outcomes. **Healthy,** Happy Patients. www.directrx.com



## Su receta será procesada por DirectRx Pharmacy.

Esto es lo que puede esperar de nosotros en el futuro:

- Una llamada de bienvenida personalizada
- Revisión completa de su seguro medico
- Entrega gratuita y cómoda
- Atención y apoyo continuos

Un miembro de nuestro equipo se comunicará con usted muy pronto.

Escanee el código QR para agregar el número de teléfono de DirectRx, (855) 362-3397, a su lista de contactos.



Conexiones **Compasivas**. Resultados **Exitosos**. Pacientes **Sanos** y Felices. www.directrx.com

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#### Black Lung Referral Form

830 KIRTS BLVD, STE 300 • TROY, MI 48084 855.362.3397 • Fax: 877.892.4007

SPANISH SPEAKING

FOR MORE INFORMATION/REFERRAL FORMS VISIT WWW.DIRECTRX.COM

Patient Information				
Name	Date of Birth	Home Phone Number	Other Phone Number	
Addross		City	State 7in	
Address		City	State Zip	
Patient SS # [Recommended]		Allergies	No Known Allergies	
Doctor/ <b>Prescriber</b> Info [NPI # is mandator	y .]			
Name		Office Contact	Office Contact	
Address		City	State Zip	
NPI#		Phone #	Fax #	
Email Address:				
Statement of Medical Necessity *** Pl	ease Fax recent clinic	al notes, tests with the prescription.		
Medicare/Medicaid maximum allowed Lengtl	<b>h of Need</b> is 12 months.	Date Last Seen:		
Length of Need: months (99=Lifetime)		Diagnosis/ ICD-10:	J60 – Coalworker's Pneumoconiosis	
Spirometry Results:	Date:	Other Diagnosis/ICD -10:		
Medication	Dose/Strength	Frequer	ncy/Directions	
Albuterol/Ipratropium (DuoNeb)	2.5-0.5mg/3ml	QID (120 vials) TID (90 vials)	BID (60 vials) QD (30 vials)	
Albuterol Sulfate	0.63mg/3ml 1.25mg/3ml	QID (120 vials) TID (90 vials)		
	2.5mg/3ml		BID (60 vials) QD (30 vials)	
Arformoterol Tartrate (Brovana®)	15mcg/2ml	BID (60 vials) QD (30 vials)		
Budesonide <sup>®</sup> (Pulmicort <sup>®</sup> )	0.25mg/2ml	BID (60 vials) QD (30 vials)		
	0.5mg/2ml			
Ipratropium Bromide	0.2mg/ml	QID (120 vials) TID (90 vials)	BID (60 vials) QD (30 vials)	
Perforomist <sup>®</sup> (formoterol fumarate)	20mcg/2ml	BID (60 vials) QD (30 vials)		
D Tobramycin (Tobi <sup>®</sup> )	300mg/5ml	BID (56 vials, 28 day supply)	Monthly Every other Month	
□ Yupelri (Revefenacin) (30 vials)	175mcg/3ml	Inhale one vial once daily via neb	ulizer.	
Other Medication:		Directions:		
Medication Administration Supplies: Refills good for TWELVE MONTHS, unless otherwise noted. Refills:				
Nebulizer/Compressor (E0570) Trach Mask 1/mo (A7525) Disposable Filter 2/mo (A7013)				
Disposable Neb Kit 1/mo (A7003) Reusable Neb Kit 1/6 mo (A7005) Mask 1/mo (A7015)				
<u> </u>				

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. I authorize DirectRx, Inc and it's representatives to act as an agent to initiate & execute the insurance prior authorization and any future fills of the same prescription for the patient listed above. I understand that I may revoke this right at any time by providing written notice to DirectRx, Inc.

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