DirectRx®
PHARMACY

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

Fax

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

e-Prescribe

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

Provide to Patient

DirectRx®
PHARMACY

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.
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Proporcionar al Paciente

DirectRx®
PHARMACY

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

DirectRx® PHARMACY

☐ SPANISH SPEAKING

Bronchiectasis 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

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

Address | City | State | Zip

Patient SS# [Recommended] | ☐ Allergies | ☐ No Known Allergies

Doctor/Prescriber Info [NPI # is mandatory .]

Name | Office Contact

Address | City | State | Zip

NPI # | Phone # | Fax #

Email Address:

Statement of Medical Necessity *** Please Fax recent clinical notes, tests with the prescription.

Date Last Seen:

Medicare/Medicaid maximum allowed Length of Need is 12 months.

Diagnosis/ICD-10:

- ☐ J47.0 - Bronchiectasis with acute lower respiratory infection
- ☐ J47.1 - Bronchiectasis with (acute) exacerbation
- ☐ J47.9 - Bronchiectasis, uncomplicated
- ☐ A15.0 - Tuberculous
- ☐ E84.0 - Cystic Fibrosis with Pulmonary Manifestations
- ☐ Q33.4 - Congenital Bronchiectasis

Medication	Dose/Strength	Quantity	Frequency/Directions
☐ Tobramycin (Tobi®) It is reasonable and medically necessary to administer Tobramycin to this patient as they have been diagnosed with one or more of the above documented diagnoses.	☐ 300mg/5ml	☐ Monthly - 1 vial BID (56 vials, 28 day supply) ☐ Every other month - 1vial BID (56 vials, 56 day supply)	Directions:
☐ Acetylcysteine Inhalation Solution	☐ 30 ml/10% ☐ 30 ml/20%	☐ Qty Sufficient for 30 Days	Directions for Use (ml)
☐ BD Syringes	☐ 21G 1 1/2	☐ Qty Sufficient for 30 Days	Directions for Use (ml): Use as directed to draw up Acetylcysteine.
☐ Sodium Chloride Neb Inhalation	☐ 4ml/3.0% ☐ 4ml/3.5% ☐ 4ml/7.0%	☐ Qty Sufficient for 30 Days	Directions for Use (ml)

Medication Administration Supplies: **Refills good for TWELVE MONTHS, unless otherwise noted.** **Refills:** _____

- ☐ Nebulizer/Compressor (E0570)
- ☐ Mask 1/mo (A7015)
- ☐ Disposable Filter 2/mo (A7013)
- ☐ Disposable Neb Kit 1/mo (A7003)
- ☐ Breath-Enhanced Reusable Neb Kit 1/6 mo (A7005) [Tobramycin only]
- ☐ Trach Mask 1/mo (A7525)
- ☐ Reusable Neb Kit 1/6 mo (A7005)

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.