

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



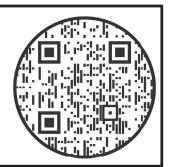
Your prescription will be processed by DirectRx Pharmacy.

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



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.





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
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 Leng	ith of Nood is 12 months	Diagnosis/ICD-	10: J47.0 - Bronchiectasis with acute lower respiratory infection J47.1 - Bronchiectasis with (acute) exacerbation
Medicare/Medicard maximum anowed Leng	ui oi need is 12 months.	•	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®)	☐ 300mg/5ml	Monthly - 1 vial BID	Directions:
It is reasonable and medically necessary to administer Tobramycin to this patient as they have been diagnosed		(56 vials, 28 day supply)	
with one or more of the above documented diagnoses.		Every other month - 1vial BID (56 vials, 56 day supply)	
		(c c, c c app. y)	
Acetylcysteine Inhalation Solution	30 ml/10%	Qty Sufficient for 30 Days	Directions for Use (ml)
	30 ml/20%		
DD Cowing as	21G 1 1/2	☐ Qty Sufficient for 30 Days	Directions for Use (ml): Use as directed to
☐ BD Syringes	21011/2	= Qty sumcleme for 50 bays	draw up Acetylcysteine.
Sodium Chloride Neb Inhalation	☐ 4ml/3.0%	Qty Sufficient for 30 Days	Directions for Use (ml)
	☐ 4ml/3.5%		
	☐ 4ml/7.0%		
Medication Administration Supplies: Refills good for TWELVE MONTHS, unless otherwise noted. Refills:			
Nahulian/Caranyaanay/F0F70)			
Nebulizer/Compressor (E0570)	Disposable Neb Kit 1/mo (A7003)		☐ Trach Mask 1/mo (A7525)
Mask 1/mo (A7015)	Breath-Enhanced Reusable Neb Kit		Reusable Neb Kit 1/6 mo (A7005)
Disposable Filter 2/mo (A7013)	1/6 mo (A7005) [Tobramycin only]		
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.

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. He 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.

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