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®
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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

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

Crohn's & Ulcerative Colitis 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

Date Shipment Needed: **Ship to:** ☐ Patient ☐ Clinic

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 to expedite the Prior Authorization.

Patient Weight: ☐ lbs. ☐ 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
☐ **Cimzia®** (certolizumab pegol) *Crohn's Disease Indication	☐ 200mg/mL Starter Kit	☐ Inject 400mg on day 1 then repeat dose 2 and 4 weeks after initial dose.		
	☐ 200mg/mL Vial ☐ 200mg/mL Prefilled Syringes	☐ Inject 400mg every 4 weeks		
☐ **Humira®** (adalimumab) *Crohn's Disease and Ulcerative Colitis Indication	☐ 40mg/0.8mL Crohn's Disease Starter Package Pen Kit ☐ 40mg/0.8mL Prefilled Pen Kit ☐ 40mg/0.8mL Prefilled Syringe Kit	☐ Initial: Inject 160mg on day 1, then 80mg on day 15, then 40mg every other week ☐ Maintenance: Inject 40mg SQ every other week.		
☐ **Simponi®** (golimumab) *Ulcerative Colitis Indication	☐ Smartject 100mg/mL Prefilled ☐ Syringes 100mg/mL	☐ Initial: Inject 200mg SQ at week 1, then 100mg at week 2, then start maintenance at week 6 ☐ Maintenance: Inject 100mg every 4 weeks starting at week 6		
☐ 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. 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.