

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



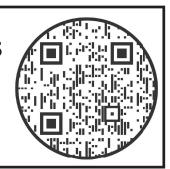
Your prescription will be processed by DirectRx Pharmacy.

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.





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	me Date of Birth		Home Phone Number		Other Phone Number		
Address		City		State Zip			
Patient SS# [Recommended]		Allergies No Known All			llorgies		
Tatient 55% [necommended]	Allergies		No ki	IOWII AI	lergies		
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 ** Plea	ase FAX recent clinical notes, tests, v	with the prescription	to expedite the Prior	Authorization.			
Patient Weight:							
ICD10 Code:							
Other reasons for treatment (complete or attac	h 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.				
Croim's Disease malcation	200mg/mL Vial						
	200mg/mL Prefilled Syringes		Inject 400mg every 4 weeks				
Humira® (adalimumab)	40mg/0.8mL Crohn's Disease Starter Package Pen Kit		Initial: Inject 160mg on day 1, then 80mg on day 15, then 40mg every other week				
*Crohn's Disease and Ulcerative Colitis Indication	40mg/0.8mL Prefilled Pen Kit						
	40mg/0.8mL Prefilled Syringe Kit		Maintenance: Inje	ct 40mg SQ every other week.			
Simponi® (golimumab)			Initial: Inject 200mg SQ at week 1, then 100mg at				
*Ulcerative Colitis Indication			week 2, then start maintenance at week 6				
			Maintenance: Inject 100mg every 4 weeks starting at week 6				
			weeks starting	ат week б			
Other:							
	I		l				
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.

©2013 DirectRx · All Rights Reserved