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.
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

Multiple Sclerosis 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.

Diagnosis/ICD-10: ☐ G35 Multiple Sclerosis ☐ Other: | Number of relapses in past year:

Last MRI date: | Any MRI Changes? ☐ Yes ☐ No | Prior failed medication:

Type: ☐ Relapsing-remitting ☐ Primary-progressive ☐ Secondary-progressive ☐ Progressive-relapsing

Medication	Dose/Strength	Sig	Qty	Refills
☐ Avonex®	☐ 30mcg PFS #4 ☐ 30mcg Pen #4 ☐ 30mcg SDV #4	☐ **Dose Titration: (Available using PFS)** Week 1: Inject 7.5mcg IM; Week 2: Inject 15mcg IM Week 3: Inject 22.5mcg IM; Week 4: Inject 30mcg IM ☐ **Maintenance Dose:** Inject 30mcg IM once weekly		
☐ Betaseron® ☐ Extavia®	☐ 0.3mg vial #14 ☐ 0.3mg vial #15	☐ **Dose Titration:** Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD Weeks 5-6: Inject 0.1875mg/0.75ml subcutaneously QOD Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD ☐ **Maintenance Dose:** 0.25mg/1ml subcutaneously QOD		
☐ Copaxone®	☐ 20mg PFS #30 ☐ 40mg PFS #12	☐ Inject 20mg subcutaneously once daily ☐ Inject 40mg three times weekly (48 hrs apart)		
☐ Glatopa™	☐ 20 mg PFS #30	☐ Inject 20mg subcutaneously once daily		
☐ Gilenya®	☐ 0.5mg capsule	☐ Take 0.5mg po QD		
☐ Rebif®	☐ Titration Pack ☐ Rebidose Titration Pack ☐ 22mcg PFS ☐ 22mcg Rebidose Injection ☐ 44mcg PFS ☐ 44mcg Rebidose Injection	☐ **Dose Titration: Target Dose 22mcg three times weekly** Weeks 1-2: 4.4mcg three times weekly (48 hrs apart) Weeks 2-4: 11mcg three times weekly (48 hrs apart) ☐ **Maintenance Dose:** Inject 22mcg (0.5ml) SQ three times a week (48hrs apart) ☐ **Dose Titration: Target Dose 44mcg three times weekly** Weeks 1-2: Inject 8.8mcg subcutaneously three times a week Weeks 3-4: Inject 22mcg subcutaneously three times a week ☐ **Maintenance Dose:** Inject 44mcg (0.5ml) SQ three times a week (48hrs apart)		

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.