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

Psoriasis 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

Drug Delivery Info

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 ☐ kgs Diagnosis/ICD-10: ☐ L40.0 Psoriasis vulgaris ☐ L40.8 Other Psoriasis ☐ L40.9 Psoriasis, unspecified

Indicate treatmentfailure or intolerance to the following drugs: ☐ Enbrel ☐ Humira ☐ Simponi ☐ Stelara ☐ Methotrexate ☐ PUVA ☐ UVB

☐ Topicals (please list): ☐ Others (please list):

☐ TB/PPD Test Given Date:

Medication	Dose/Strength	Sig	Qty	Refills
☐ Enbrel® (etanercept)	☐ 50mg/mL Sureclick® autoinjector ☐ 50mg/ml prefilled syringes ☐ 25mg/0.5ml prefilled syringes ☐ 25mg vial	☐ Psoriasis Induction Dose: Inject 50 mg SC Twice a week (72-96 hours apart) x3 months ☐ Maintenance Dose: Inject 50 mg SC once a week		
☐ Humira® (adalimumab)	☐ 40mg/0.8mL prefilled auto pen ☐ 40mg/0.8mL prefilled syringes ☐ Psoriasis Starter Pack	☐ **Starter Pack:** 80mg SC Day 1, then 40mg one week later (Day 8), then 40mg every other week thereafter ☐ **Maintenance Dose:** 40mg SC every two weeks ☐ Inject 40mg SC ONCE a week		
☐ Otezla®	☐ Starter Pack ☐ 30mg	☐ Day 1: 10 mg in morning ☐ Day 2: 10 mg in morning and 10 mg in evening ☐ Day 3: 10 mg in morning and 20 mg in evening ☐ Day 4: 20 mg in morning and 20 mg in evening ☐ Day 5: 20 mg in morning and 30 mg in evening ☐ Day 6 and thereafter: 30 mg twice daily ☐ 30mg sig: Take one tablet by mouth twice daily.		
☐ Oxsoralen-Ultra® (methoxsalen)	☐ 10mg			
☐ Stelara® (ustekinumab)	☐ 45mg/0.5mL prefilled syringe ☐ 90mg/1mL prefilled syringe	☐ **Initiation Dose:** Inject the contents of 1 prefilled syringe SC initially Day 1 ☐ **Maintenance Dose:** Inject the contents of 1 prefilled syringe SC starting Day 29 & every 12 weeks thereafter		

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.