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

(A-N) Rheumatology 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.

Diagnosis/ICD-10: ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ L40.59 Psoriatic Arthritis ☐ _____

Patient Weight: TB/PPD Test given Date:

Prior Medications Failed:

Medication	Dose/Strength	Directions	Qty	Rfs
Actemra® (tocilzumab)	☐ 162mg/0.9ml Prefilled syringe	☐ Inject 1 syringe SQ every week ☐ Inject 1 syringe SQ every other week		
Cimzia® (certolizumab pegol)	☐ 200mg/ml Starter Kit ☐ 200mg/ml Vial ☐ 200mg/ml Prefilled Syringes	☐ **Initial:** Inject 400mg SQ, repeat dose 2 and 4 weeks after initial dose ☐ **Maintenance:** Inject 200mg SQ every other week ☐ Inject 400mg every 4 weeks		
Enbrel (etanercept)	☐ 25mg multi use vial ☐ 25mg/0.5ml Prefilled Syringe ☐ 50mg/ml Prefilled Syringe ☐ 50mg/ml SureClick Autoinjector	☐ Once Weekly: Inject 50mg SQ once weekly ☐ Twice Weekly: Inject 25mg SQ twice weekly (72 to 96 hours apart) ☐ Twice Weekly: Inject 50mg SQ twice weekly		
Humira (adalimumab)	☐ 40mg/0.8ml Prefilled Pen Kit ☐ 40mg/0.8ml Prefilled Syringe Kit	☐ Inject 40mg SQ every other week. ☐ Inject 40mg SQ every week (Not Taking Methotrexate)		
Humira® Injection Training	☐ The HUMIRA Complete Program is to provide subcutaneous injection training for HUMIRA, including administration by a HUMIRA Nurse (RN) as needed.			

_____ _____

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.