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

Hyponatremia Samsca(Tolvaptan) 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

Caregiver Information

Caregiver Name: | Relation to Patient: | Phone Number:

Hospital Information

Hospital Contact Name: | Hospital Name: | Phone Number:

Prescriber Information

Prescriber Name: | City | State | Zip

Address | Phone # | Fax #

NPI # | Email Address:

Preferred Method of Prior Authorization: Cover My Meds ☐ Contact Insurance Directly ☐ Other

Statement of Medical Necessity

ICD-10 Diagnosis code(s): **Please check all that apply

☐ E87.1 Hypo-osmolality and Hyponatremia ☐ E22.2 SIADH ☐ Other:

Inpatient Treatment Initiation Date: | Anticipated Discharge Date:

Has the patient been admitted or readmitted to the hospital in the last 30 to 90 days? Yes ☐ No ☐

Has the patient failed on other therapies? (e.g. fluid restriction or high dose diuretics) Yes ☐ No ☐

Based on the patient's history, is patient at risk for hospital readmission in the next 30 days? Yes ☐ No ☐

Serum Sodium prior to Samsca (Tolvaptan) initiation: ____ mEq/L

Total quantity dispensed since hospital admission: ____

Will patient receive a dose of Samsca (Tolvaptan) on discharge date? Yes ☐ No ☐

Medication	Dose/Strength	Sig	Qty	Refills
☐ Samsca (Tolvaptan)	☐ 15mg ☐ 30mg			

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.