

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
clinical.**

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



Provide to
Patient

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 | info@directrx.com

Compassionate Connections. Successful Outcomes. Healthy, Happy Patients.

www.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.**



Patient Information

Name Date of Birth Home Phone Number Other Phone Number

Address City State Zip

Patient SS # [Recommended] Allergies No Known Allergies

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.

Medicare/Medicaid maximum allowed **Length of Need** is 12 months. Date Last Seen:

Length of Need: months (99=Lifetime) Diagnosis/ ICD-10: J60 – Coalworker’s Pneumoconiosis

Spirometry Results: Date: Other Diagnosis/ICD -10:

Medication	Dose/Strength	Frequency/Directions
<input type="checkbox"/> Albuterol/Ipratropium (DuoNeb)	<input type="checkbox"/> 2.5-0.5mg/3ml	<input type="checkbox"/> QID (120 vials) <input type="checkbox"/> TID (90 vials) <input type="checkbox"/> BID (60 vials) <input type="checkbox"/> QD (30 vials)
<input type="checkbox"/> Albuterol Sulfate	<input type="checkbox"/> 0.63mg/3ml <input type="checkbox"/> 1.25mg/3ml <input type="checkbox"/> 2.5mg/3ml	<input type="checkbox"/> QID (120 vials) <input type="checkbox"/> TID (90 vials) <input type="checkbox"/> BID (60 vials) <input type="checkbox"/> QD (30 vials)
<input type="checkbox"/> Arformoterol Tartrate (Brovana [®])	<input type="checkbox"/> 15mcg/2ml	<input type="checkbox"/> BID (60 vials) <input type="checkbox"/> QD (30 vials)
<input type="checkbox"/> Budesonide [®] (Pulmicort [®])	<input type="checkbox"/> 0.25mg/2ml <input type="checkbox"/> 0.5mg/2ml	<input type="checkbox"/> BID (60 vials) <input type="checkbox"/> QD (30 vials)
<input type="checkbox"/> Ipratropium Bromide	<input type="checkbox"/> 0.2mg/ml	<input type="checkbox"/> QID (120 vials) <input type="checkbox"/> TID (90 vials) <input type="checkbox"/> BID (60 vials) <input type="checkbox"/> QD (30 vials)
<input type="checkbox"/> Perforomist [®] (formoterol fumarate)	<input type="checkbox"/> 20mcg/2ml	<input type="checkbox"/> BID (60 vials) <input type="checkbox"/> QD (30 vials)
<input type="checkbox"/> Tobramycin (Tobi [®])	<input type="checkbox"/> 300mg/5ml	<input type="checkbox"/> BID (56 vials, 28 day supply) <input type="checkbox"/> Monthly <input type="checkbox"/> Every other Month
<input type="checkbox"/> Yupelri (Revefenacin) (30 vials)	<input type="checkbox"/> 175mcg/3ml	<input type="checkbox"/> Inhale one vial once daily via nebulizer.
<input type="checkbox"/> Other Medication:		Directions:

Medication Administration Supplies: Refills good for TWELVE MONTHS, unless otherwise noted. Refills: _____

- Nebulizer/Compressor (E0570) Trach Mask 1/mo (A7525) Disposable Filter 2/mo (A7013)
- Disposable Neb Kit 1/mo (A7003) Reusable Neb Kit 1/6 mo (A7005) Mask 1/mo (A7015)

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.

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