

## 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**

\*Provide to Patient



Your prescription is being filled through DirectRx Pharmacy,  
a full-service pharmacy provider.

Here's what you can expect:

- Initial call to process your prescription
- Explanation of prior authorization (\*if applicable)
- A full benefit and copay assistance review
- Set-up of **free** and convenient delivery
- Pharmacist counseling with 24hr call assistance

If you have any questions, please feel free to call DirectRx at:

**Toll Free: 855.362.3397 (press 0)**

**248.280.2270 (press 0)**



830 Kirts Blvd STE 300 • Troy, MI 48084  
Phone: 855.362.3397 • Fax: 877.892.4007

\*Provide to Spanish Speaking Patient



Su receta está siendo completada por la farmacia DirectRx,  
un proveedor farmacéutico de servicio completo.

Esto es lo que usted puede esperar:

- Una llamada inicial el mismo día para procesar su receta
- Explicación de la autorización previa (\*Si es aplicable)
- Una revisión completa de la asistencia de beneficios y copagos
- Configuración de entrega gratuita y conveniente
- Asesoramiento farmacéutico con asistencia telefónica las 24 horas

Si no recibe noticias de nosotros dentro de 24 horas o tiene alguna pregunta,  
Por favor llámenos.

**Llamadas Gratuitas: 855.362.3397 (presione 0)**

**248.280.2270 (presione 0)**



830 Kirts Blvd STE 300 • Troy, MI 48084  
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**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
<input type="checkbox"/> Avonex <sup>®</sup>	<input type="checkbox"/> 30mcg PFS #4 <input type="checkbox"/> 30mcg Pen #4 <input type="checkbox"/> 30mcg SDV #4	<input type="checkbox"/> <b>Dose Titration: (Available using PFS)</b> Week 1: Inject 7.5mcg IM; Week 2: Inject 15mcg IM Week 3: Inject 22.5mcg IM; Week 4: Inject 30mcg IM <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 30mcg IM once weekly		
<input type="checkbox"/> Betaseron <sup>®</sup>	<input type="checkbox"/> 0.3mg vial #14	<input type="checkbox"/> <b>Dose Titration:</b> 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 <input type="checkbox"/> <b>Maintenance Dose:</b> 0.25mg/1ml subcutaneously QOD		
<input type="checkbox"/> Extavia <sup>®</sup>	<input type="checkbox"/> 0.3mg vial #15			
<input type="checkbox"/> Copaxone <sup>®</sup>	<input type="checkbox"/> 20mg PFS #30 <input type="checkbox"/> 40mg PFS #12	<input type="checkbox"/> Inject 20mg subcutaneously once daily <input type="checkbox"/> Inject 40mg three times weekly (48 hrs apart)		
<input type="checkbox"/> Glatopa <sup>™</sup>	<input type="checkbox"/> 20 mg PFS #30	<input type="checkbox"/> Inject 20mg subcutaneously once daily		
<input type="checkbox"/> Gilenya <sup>®</sup>	<input type="checkbox"/> 0.5mg capsule	<input type="checkbox"/> Take 0.5mg po QD		
<input type="checkbox"/> Rebif <sup>®</sup>	<input type="checkbox"/> Titration Pack <input type="checkbox"/> Rebidose Titration Pack <input type="checkbox"/> 22mcg PFS <input type="checkbox"/> 22mcg Rebidose Injection <input type="checkbox"/> 44mcg PFS <input type="checkbox"/> 44mcg Rebidose Injection	<input type="checkbox"/> <b>Dose Titration: Target Dose 22mcg three times weekly</b> Weeks 1-2: 4.4mcg three times weekly (48 hrs apart) Weeks 2-4: 11mcg three times weekly (48 hrs apart) <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 22mcg (0.5ml) SQ three times a week (48hrs apart) <input type="checkbox"/> <b>Dose Titration: Target Dose 44mcg three times weekly</b> Weeks 1-2: Inject 8.8mcg subcutaneously three times a week Weeks 3-4: Inject 22mcg subcutaneously three times a week <input type="checkbox"/> <b>Maintenance Dose:</b> 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.

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