

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.

Diagnosis/ICD-10: Date Last Seen: Medicare/Medicaid maximum allowed Length of Need is 12 months.

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"/> Ohtuvayre (ensifentrine)	<input type="checkbox"/> 3mg/2.5ml	<input type="checkbox"/> BID (60 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"/> Monthly - 1 vial BID (56 vials, 28 day supply) <input type="checkbox"/> Every other month - 1 vial BID (56 vials, 56 day supply)
<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:

Refills good for TWELVE MONTHS, unless otherwise noted.

Refills: _____

- Nebulizer/Compressor (E0570) Trach Mask 1/mo (A7525) Disposable Filter 1/2mo (A7013)
- Disposable Neb Kit 2/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.

IMPORTANT CONFIDENTIALLY NOTICE: This and any documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity name above. He authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the content of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.