

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 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)



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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

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® (tocilizumab)	<input type="checkbox"/> 162mg/0.9ml Prefilled syringe	<input type="checkbox"/> Inject 1 syringe SQ every week <input type="checkbox"/> Inject 1 syringe SQ every other week		
Cimzia® (certolizumab pegol)	<input type="checkbox"/> 200mg/ml Starter Kit <input type="checkbox"/> 200mg/ml Vial <input type="checkbox"/> 200mg/ml Prefilled Syringes	<input type="checkbox"/> Initial: Inject 400mg SQ, repeat dose 2 and 4 weeks after initial dose <input type="checkbox"/> Maintenance: Inject 200mg SQ every other week <input type="checkbox"/> Inject 400mg every 4 weeks		
Enbrel (etanercept)	<input type="checkbox"/> 25mg multi use vial <input type="checkbox"/> 25mg/0.5ml Prefilled Syringe <input type="checkbox"/> 50mg/ml Prefilled Syringe <input type="checkbox"/> 50mg/ml SureClick Autoinjector	<input type="checkbox"/> Once Weekly: Inject 50mg SQ once weekly <input type="checkbox"/> Twice Weekly: Inject 25mg SQ twice weekly (72 to 96 hours apart) <input type="checkbox"/> Twice Weekly: Inject 50mg SQ twice weekly		
Humira (adalimumab)	<input type="checkbox"/> 40mg/0.8ml Prefilled Pen Kit <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe Kit	<input type="checkbox"/> Inject 40mg SQ every other week. <input type="checkbox"/> Inject 40mg SQ every week (Not Taking Methotrexate)		
Humira® Injection Training	<input type="checkbox"/> 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.

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.