

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
Orencia [®] (abatacept)	<input type="checkbox"/> 125mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 125mg SQ once per week		
Otezla [®] (apremilast)	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg	<input type="checkbox"/> Day 1: 10 mg in morning <input type="checkbox"/> Day 2: 10 mg in morning and 10 mg in evening <input type="checkbox"/> Day 3: 10 mg in morning and 20 mg in evening <input type="checkbox"/> Day 4: 20 mg in morning and 20 mg in evening <input type="checkbox"/> Day 5: 20 mg in morning and 30 mg in evening <input type="checkbox"/> Day 6 and thereafter: 30 mg twice daily <input type="checkbox"/> 30mg sig: Take one tablet by mouth twice daily.		
Simponi [®] (golimumab)	<input type="checkbox"/> 50mg/0.5ml SmartJect <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 50mg SQ once per month		
Stelara [®] (ustekinumab)	<input type="checkbox"/> 45mg/0.5mL Prefilled syringe <input type="checkbox"/> 90mg/ml Prefilled Syringe	<input type="checkbox"/> Initial: Inject 45mg initially and 4 weeks later followed by 45mg every 12 weeks <input type="checkbox"/> Initial: Inject 90mg initially and 4 weeks later followed by 90 mg every 12 weeks <input type="checkbox"/> Maintenance: Inject 45mg every 12 weeks <input type="checkbox"/> Maintenance: Inject 90mg every 12 weeks		
Xeljanz [®] (tofacitinib)	<input type="checkbox"/> 5mg tablets	<input type="checkbox"/> 5mg PO twice daily <input type="checkbox"/> 5mg PO once daily		
Xeljanz [®] XR (tofacitinib)	<input type="checkbox"/> 11mg tablets	<input type="checkbox"/> 11mg PO once daily		

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.