Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

Nephrology Referral Form (N-Z)

3233 Corporate Ct.
Ellicott City, MD 21043

LIFELINE SPECIALTY PHARMACY

Send your Rx to: **Fax Number: 410-203-1515** **Phone Number: 410-203-1010** **Toll Free Number: 1-833-4-LIFELINE** **NPI: 1568975464**

If you have questions or concerns, please contact us.

Date Medication Needed:_____ **Ship To:** ☐ Patient's Home ☐ Prescriber's Office Injection training by pharmacy? ☐

1: Patient Information

Patient Name:_____ **Birthdate:**_____ **Sex:** ☐ Male ☐ Female **Height:**_____ **Weight:**_____ ☐ lbs. ☐ kg.

Soc. Sec. #:_____ **Preferred Phone:**_____ **Known Allergies:** _____

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Alternate Caregiver Name:_____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name:_____ **DEA#:**_____ **NPI#:**_____ **Tax ID#:** _____

Address:_____ **Phone:**_____ **Fax:** _____

City, State, Zip: **Key Contact:** **Phone:**

Office Contact Name: _____ Phone Number: _____ CoverMyMeds Email: _____

Please fax recent clinical notes, labs/rounding reports with this prescription to expedite the prior authorization process if necessary. We complete prior authorizations through CoverMyMeds. Please include the contact email for you or your prescriber's CoverMyMeds account to receive key numbers as we may need to send for the final submission. If you do not have a CoverMyMeds account please reach out to us here at the pharmacy and we will assist in creating new accounts.

3: Diagnosis/Clinical Information

Diagnosis: _____ **ICD-10 Code:**_____ ☐ **Prior failed medications** _____

4: Patient Support and Injection Training Authorization

I authorize Lifeline Specialty Pharmacy to enroll the patient in the pharmaceutical manufacturer support program that pertains to the prescribed therapy. The purpose of this enrollment is to assist the patient in receiving services, like injection training and administration of the therapy by a nurse. The patient also authorizes the pharmacy to transmit any pertinent information that the manufacturer needs to effectively provide the medications and services that are available with the therapy, as well as, to use unidentifiable data to conduct market research. The manufacturer may contact me with information for research and educational purposes. The patient can revoke this authorization without any effect to the patient's ability to acquire the therapy. If the patient chooses to revoke this authorization, he/she may do so by writing a letter to Lifeline Specialty Pharmacy at 3233 Corporate Court, Ellicott City, MD, 21043 .

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ Neoral	☐ 25 mcg/ml ☐ 25 mcg/0.42 ml ☐ 40 mcg/ml	☐ Take _____ capsule(s) by mouth twice a day ☐ Take _____ capsule(s) by mouth twice a day		
☐ Phoslyra	☐ 667 mg/5 ml	☐ Take 10 ml by mouth with each meal ☐ Take _____ ml by mouth _____ times a day with meals		
☐ Procrit	☐ 2000 u/ml ☐ 10000 u/ml ☐ 3000 u/ml ☐ 20000 u/ml (1 ml vial) ☐ 4000 u/ml ☐ 10000 u/ml (2 ml vial)	☐ Inject _____ ml SC once a week ☐ Inject _____ ml three times a week ☐ Inject _____ ml SC every _____ weeks		
☐ Rapamune	☐ 0.5 mg ☐ 2 mg ☐ 1 mg ☐ 1mg/ml	☐ Take 1 tablet by mouth once daily ☐ Take _____ tablet(s) by mouth _____ times a day ☐ Take _____ ml by mouth _____ times a day ☐ Other: _____		
☐ Renagel	☐ 400 mg ☐ 800 mg	☐ Take 1 tablet by mouth three times a day with meals ☐ Take _____ tablet(s) by mouth _____ times a day with meals		
☐ Renvela	☐ 800 mg ☐ 2.4 gm packet	☐ Take 1 tablet by mouth three times a day with meals ☐ Take _____ tablet(s) by mouth _____ times a day with meals ☐ Dissolve _____ packet(s) in minimum 2 ounces of wter and drink _____ times a day		
☐ Retacrit	☐ 2000 u/ml SDV ☐ 10000 u/ml SDV ☐ 3000 u/ml SDV ☐ 40000 u/ml SDV ☐ 4000 u/ml SDV	☐ Inject _____ ml SC once a week ☐ Inject _____ ml SC three times a week ☐ Inject _____ ml SC every _____ weeks		
☐ Sandimmune	☐ 25 mg ☐ 100 mg	☐ Take _____ capsule(s) by mouth _____ times a day		
☐ Sensipar	☐ 30 mg ☐ 90 mg ☐ 60 mg	☐ Take 1 tablet by mouth once daily with food ☐ Take _____ tablet(s) by mouth _____ times a day with food		
☐ Velphoro	☐ 500 mg	☐ Chew _____ tablet(s) by mouth_____ times a day with food		
☐ Zortress	☐ 0.25 mg ☐ 0.5 mg ☐ 0.75 mg	☐ Take 1 tablet(s) by mouth two times a day ☐ Take _____ tablet(s) by mouth _____ times a day		

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

# of Prescriptions:____