

Rheumatoid Arthritis Prescription Referral Form A-N

3233 Corporate Ct.
Ellicott City, MD 21043



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 Pick-up (store location): _____ 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 | Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis: _____ ICD-10 Code _____ Is patient currently on RA therapy? Yes No
TB/PPD test given? Yes No Serious/Active Infection? Yes No Medications: _____
Prior failed medications (medication and duration of treatment/reason for d/c) _____

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.

4: Prescription Information | Xeljanz NOT to be used in combination with biologic DMARD's

Medication	Dose/Strength	Sig	Qty.	Refills
<input type="checkbox"/> Actemra	<input type="checkbox"/> 162mg Prefilled Syringe <input type="checkbox"/> 162mg Pen	<input type="checkbox"/> Inject 162mg SC <input type="checkbox"/> once a week or <input type="checkbox"/> every other week		
	<input type="checkbox"/> _____ Vial	<input type="checkbox"/> Inject _____ mg every 4 weeks		
<input type="checkbox"/> Benlysta	200 mg/ml Syringe 120mg Vial	Inject 200mg every week		
	<input type="checkbox"/> 200 mg/ml Autoinjector 400mg Vial	Other: _____		
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Cimzia Starter Kit	<input type="checkbox"/> Induction Dose: Inject 400mg SC on Day 0, at week 2, & week 4		
	<input type="checkbox"/> 200x2 Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 400mg SC once every 4 weeks		
	<input type="checkbox"/> 200x2 SDV	<input type="checkbox"/> Inject 200mg SC once every 2 weeks		
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg Sensoready Pen	<input type="checkbox"/> Induction Dose: Inject <input type="checkbox"/> 150mg or <input type="checkbox"/> 300mg SC weekly for 5 weeks		
	<input type="checkbox"/> 150mg PFS	<input type="checkbox"/> Maintenance Dose: Inject <input type="checkbox"/> 150 or <input type="checkbox"/> 300mg SQ every 4 weeks		
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50mg Sureclick	<input type="checkbox"/> Inject 50mg SC once a week		
	<input type="checkbox"/> 50mg Syringe			
	<input type="checkbox"/> 50mg Mini	<input type="checkbox"/> Inject _____mg SC _____a week (72-96 hours apart)		
	<input type="checkbox"/> 25mg PFS			
<input type="checkbox"/> 25mg/ml Vials				
<input type="checkbox"/> Humira (Citrate Free)	<input type="checkbox"/> 40mg Pen	<input type="checkbox"/> Inject 40mg SC every week		
	<input type="checkbox"/> 40mg Prefilled Syringe	<input type="checkbox"/> Inject 40mg SC every other week		
<input type="checkbox"/> Humira	<input type="checkbox"/> 40mg Pen	<input type="checkbox"/> Inject 40mg SC every week		
	<input type="checkbox"/> 40mg Prefilled Syringe	<input type="checkbox"/> Inject 40mg SC every other week		
<input type="checkbox"/> Inflectra	<input type="checkbox"/> 100mg Vials	<input type="checkbox"/> Infuse _____mg at week 0, 2, 6, and then every 8 weeks thereafter		
		<input type="checkbox"/> Infuse _____mg SC every _____weeks		
<input type="checkbox"/> Kevzara	<input type="checkbox"/> 150mg Prefilled Syringe	<input type="checkbox"/> Inject 1 syringe SC every 2 weeks		
	<input type="checkbox"/> 200mg Prefilled Syringe			

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 Permissible

Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VAJOH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____