Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Rheumatoid Arthritis Prescription Referral Form A-N

3233 Corporate Ct.
Ellicott City, MD 21042

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 ☐ 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, 21042 .

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

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

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 VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

# of Prescriptions: _____