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

Asthma/Allergy Referral Form

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 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:**_____

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

Diagnosis:_____ **ICD-10 Code**_____ **Location:** ☐ **Hands** ☐ **Feet** ☐ **Knees** ☐ **Spine** **Other:**_____ **Latex allergy?** **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	Weight/Age		Sig	Qty.	Refills
☐ **Cinqair**	☐ 100 mg vial			☐ 3 mg/kg IV infusion once every 4 weeks Patient's weight _____		
☐ **Dupixent**	☐ 200 mg PFS ☐ 300 mg PFS ☐ 200 mg Pen ☐ 300 mg Pen	≥ 18 years old		☐ Induction Dose: Inject 600 mg on day 1, then 300 mg on day 15 ☐ Maintenance: Inject 300mg SQ every 2 weeks		
		Patients aged 6 to 17 years old	15kg to <30kg	☐ Induction Dose: Inject 600 mg on day 1, then 300 mg on day 29 ☐ Maintenance: Inject 300mg SQ every 4 weeks		
			30kg to <60kg	☐ Induction Dose: Inject 400 mg on day 1, then 200 mg on day 15 ☐ Maintenance: Inject 200mg SQ every 2 weeks		
			≥ 60kg	☐ Induction Dose: Inject 600 mg on day 1, then 300 mg on day 15 ☐ Maintenance: Inject 300mg SQ every 2 weeks		
		Patients aged 6 months to 5 years old	5kg to <15kg	☐ Induction/ Maintenance Dose: Inject 200mg SQ every 4 weeks		
			15kg to <30kg	☐ Induction/ Maintenance Dose: Inject 300mg SQ every 4 weeks		
☐ **Xolair**	☐ 75 mg PFS ☐ 150 mg PFS ☐ 150 mg vial kit			**Dosing:** ☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg ☐ 450 mg ☐ 525 mg ☐ 600 mg ☐ Others: _____mg **Frequency:** ☐ SC every 2 weeks ☐ SC every 4 weeks ☐ SC every ___ weeks		
☐ **EpiPen**	☐ 0.3mg (0.3mL)	≥30kg		☐ **Dosing:** At first sign of allergic reaction, inject the single-dose EpiPen intramuscularly or subcutaneously into the anterolateral side of the thigh, through clothing if necessary ☐ **Frequency:** PRN		
	☐ 0.15mg (0.3mL)	15-30kg				
☐ **Other**						

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

# of Prescriptions: _____