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

Arthritis 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

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

Diagnosis and ICD-10 Code:

☐ **M06.9: Rheumatoid Arthritis** ☐ **M17.0:Bilateral Osteoarthritis of the knee** ☐ **M19.90: Osteoarthritis** ☐ **Z79.1: Long term use of NSAID**

☐ **Other diagnosis:** _____ ☐ **ICD -10 Code:** _____

☐ **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

Medication/Dose/Strength	Sig	Qty.	Refills
☐ **Duexis 800mg/26.6mg tablet**	☐ **Take 1 tablet by mouth three times per day** ☐ **Take ____ tablet(s) by mouth _____ time(s) per day** ☐ **Other:** _____	☐ **30 day supply** ☐ **90 day supply**	
☐ **Pennsaid Topical Solution 2%**	☐ **Apply 2 pumps actuation to each affected knee 2 times a day** ☐ **Apply _____ pumps actuation on _____ knee _____ times a day** ☐ **Other:** _____	☐ **30 day supply** ☐ **90 day supply**	
☐ **Rayos** ☐ **1mg** ☐ **2mg** ☐ **5mg**	☐ **Take _____ tablet(s) by mouth _____ times a day with food** ☐ **Other:** _____	☐ **30 day supply** ☐ **90 day supply**	
☐ **Vimovo** ☐ **375mg/20mg** ☐ **500mg/20mg**	☐ **Take 1 tablet two times a day at least 30 minutes before meal** ☐ **Take _____ tablet(s) by mouth _____ times a day at least 30 minutes before meal** ☐ **Other:** _____	☐ **30 day supply** ☐ **90 day supply**	

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.

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:___