

Lifeline Specialty Pharmacy

MS Prescription Referral Form

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. g.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Alternate Caregiver Name: _____ Preferred Phone: _____

2: Insurance Information

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

Primary Prescription Insurance _____ Rx Bin _____
 Rx PCN _____ Patient ID/Policy Number _____ Patient Rx Group Number _____

3: Prescriber Information

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

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

Diagnosis: CM G35 Multiple Sclerosis Other: _____
 Has the patient been previously treated for this condition? Yes No
 Prior failed medication (medication and duration of treatment/reason for d/c): _____
 Will medication be stopped before starting new therapy? Yes No
 Number of relapses in past year: _____
 Last MRI date: _____ Any MRI changes? Yes No
 Inection training completed by: _____
 Patient currently on therapy? Yes No Medication(s): _____
 Is prescriber a Neurologist? Yes No If no, include neurology consult if available. **Diagnosis:** _____

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
<input type="checkbox"/> Avonex®	<input type="checkbox"/> AVONSTARTGRIP Titration Kit <input type="checkbox"/> 30mcg Prefilled Syringe #4 <input type="checkbox"/> 30mcg Pen #4	<input type="checkbox"/> Dose Titration: • Week 1: Inject 7.5mcg IM once weekly • Week 2: Inject 15mcg IM once weekly • Week 3: Inject 22.5mcg IM once weekly • Week 4+: Inject 30mcg IM once weekly <input type="checkbox"/> Inject 30mcg IM once weekly	4 week supply	-----
<input type="checkbox"/> Betaseron®	<input type="checkbox"/> 0.3mg vial	<input type="checkbox"/> Dose Titration: • Week 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Week 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Week 5-6: Inject 0.1875 mg/0.75 subcutaneously QOD • Week 7+: Inject 0.25mg/1ml subcutaneously QOD <input type="checkbox"/> Maintenance Dose: 0.25mg /1ml subcutaneously QOD <input type="checkbox"/> Other:	4 week supply	-----
<input type="checkbox"/> Copaxone®	<input type="checkbox"/> 20mg Prefilled Syringe <input type="checkbox"/> 40mg Prefilled Syringe	<input type="checkbox"/> 20mg SQ QD <input type="checkbox"/> 40mg SQ 3 times a week, at least 48 hours apart on the same 3 days each week	4 week supply	-----
<input type="checkbox"/> Extavia®	<input type="checkbox"/> 0.3mg vial	<input type="checkbox"/> Dose Titration: • Weeks 1-2: Inject 0.0625mg/0.25ml subcutaneously QOD • Weeks 3-4: Inject 0.125mg/0.50ml subcutaneously QOD • Weeks 5-6: Inject 0.1875mg/0.75 subcutaneously QOD • Weeks 7+: Inject 0.25mg/1ml subcutaneously QOD <input type="checkbox"/> Maintenance Dose: 0.25mg /1ml subcutaneously QOD <input type="checkbox"/> Other:	4 week supply	-----
<input type="checkbox"/> Glatopa®	<input type="checkbox"/> 20mg Prefilled Syringe	<input type="checkbox"/> 20mg SQ QD	4 week supply	-----
<input type="checkbox"/> Gilenya®	<input type="checkbox"/> 0.5mg capsule	<input type="checkbox"/> Take 0.5mg po QD	4 week supply	-----
<input type="checkbox"/> Rebif® <input type="checkbox"/> Rebif Redidose®	<input type="checkbox"/> Titration Pack (8.8mcg/22mcg) <input type="checkbox"/> 22mcg Prefilled Syringe <input type="checkbox"/> 44mcg Prefilled Syringe	<input type="checkbox"/> Inject 8.8mcg subcutaneously three times a week weeks 1-2, 22mcg subcutaneously three times a week weeks 3-4, and 44mcg subcutaneously three times a week weeks 5+ (48 hours apart) <input type="checkbox"/> Maintenance: Inject 22mcg (0.5ml) SQ three times a week (48 hours apart) <input type="checkbox"/> Maintenance: Inject 44mcg (0.5ml) SQ three times a week (48 hours apart) <input type="checkbox"/> Other:	4 week supply	-----

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 _____

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: _____