

Lifeline Specialty Pharmacy

Asthma/Allergy Referral Form

6304 Woodside Ct, Ste 100
Columbia, MD 21046



Send your Rx to:

Phone: 1-833-4-LIFELINE (1-833-454-3354)
Fax: 1-833-785-4461

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	
<input type="checkbox"/> Cinqair	<input type="checkbox"/> 100 mg vial		<input type="checkbox"/> 3 mg/kg IV infusion once every 4 weeks Patient's weight _____			
<input type="checkbox"/> Dupixent	<input type="checkbox"/> 200 mg PFS <input type="checkbox"/> 300 mg PFS <input type="checkbox"/> 200 mg Pen <input type="checkbox"/> 300 mg Pen	≥ 18 years old	<input type="checkbox"/> Induction Dose: Inject 600 mg on day 1, then 300 mg on day 15 <input type="checkbox"/> Maintenance: Inject 300mg SQ every 2 weeks			
		Patients aged 6 to 17 years old	15kg to <30kg	<input type="checkbox"/> Induction Dose: Inject 600 mg on day 1, then 300 mg on day 29 <input type="checkbox"/> Maintenance: Inject 300mg SQ every 4 weeks		
			30kg to <60kg	<input type="checkbox"/> Induction Dose: Inject 400 mg on day 1, then 200 mg on day 15 <input type="checkbox"/> Maintenance: Inject 200mg SQ every 2 weeks		
		≥ 60kg	<input type="checkbox"/> Induction Dose: Inject 600 mg on day 1, then 300 mg on day 15 <input type="checkbox"/> Maintenance: Inject 300mg SQ every 2 weeks			
<input type="checkbox"/> Xolair	<input type="checkbox"/> 75 mg PFS <input type="checkbox"/> 150 mg PFS <input type="checkbox"/> 150 mg vial kit	Patients aged 6 months to 5 years old	Dosing: <input type="checkbox"/> 75 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 225 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 375 mg <input type="checkbox"/> 450 mg <input type="checkbox"/> 525 mg <input type="checkbox"/> 600 mg <input type="checkbox"/> Others: _____ mg Frequency: <input type="checkbox"/> SC every 2 weeks <input type="checkbox"/> SC every 4 weeks <input type="checkbox"/> SC every ____ weeks			
		5kg to <15kg	<input type="checkbox"/> Induction/ Maintenance Dose: Inject 200mg SQ every 4 weeks			
<input type="checkbox"/> EpiPen	<input type="checkbox"/> 0.3mg <input type="checkbox"/> 0.15mg	≥30kg	<input type="checkbox"/> 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: <input type="checkbox"/> PRN			
		15-30kg				
<input type="checkbox"/> Auvi-Q	<input type="checkbox"/> 0.1mg (Auvi-Q only)	7.5-15kg				
<input type="checkbox"/> 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 _____

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

of Prescriptions: _____