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

# Oral and Injectable Oncology Referral Form (T-Z)

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:**_____ ☐ BRAF V600 E Mutation for Tafinlar

Renal Dysfunction? ☐ Yes ☐ No Liver Dysfunction? ☐ Yes ☐ No ER: ☐ Positive ☐ Negative HER2: ☐ Positive ☐ Negative Metastatic: ☐ Yes ☐ No

☐ **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 (Please include cycle) | Qty. | Refills |
|---|---|---|---|---|
| ☐ Tafinlar | | | | |
| ☐ Tarceva | | | | |
| ☐ Targretin | | | | |
| ☐ Tasigna | | | | |
| ☐ Temodar | | | | |
| ☐ Tykerb | | | | |
| ☐ Vidaza | | | | |
| ☐ Votrient | | | | |
| ☐ Xeloda | | | | |
| ☐ Yonsa | | | | |
| ☐ Zolinza | | | | |
| ☐ Zykadia | | | | |
| ☐ Zytiga | | | | |
| ☐ 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 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:**____