

Lifeline Specialty Pharmacy

# Infectious Disease 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.  kg.  
 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: \_\_\_\_\_ ICD-10: \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_ Previous/Failed Medications \_\_\_\_\_ Date and Duration of Therapy \_\_\_\_\_

**5: Prescription Information**

Medication	Dose/Strength	Sig	Qty.	Refills
<input type="checkbox"/> Cresemba	<input type="checkbox"/> 186mg tablet	<input type="checkbox"/> Take ___ tablets by mouth ___ time(s) a day <input type="checkbox"/> Other _____		
<input type="checkbox"/> Difcid	<input type="checkbox"/> 200mg tablet	Take one tablet by mouth twice a day		
<input type="checkbox"/> Noxafil	<input type="checkbox"/> 100mg tablet	<input type="checkbox"/> Take ___ tablets by mouth ___ time(s) a day <input type="checkbox"/> Other _____		
<input type="checkbox"/> Santyl	<input type="checkbox"/> _____	Wound 1: ___ x ___ cm Location _____ Apply to wound once daily (or more frequently if dressing becomes soiled) Wound 2: ___ x ___ cm Location _____ Wound 3: ___ x ___ cm Location _____ for ___ days		
<input type="checkbox"/> Vancomycin	<input type="checkbox"/> 125mg capsule <input type="checkbox"/> 250mg capsule	<b>Clostridium Dificile:</b> Take a 125mg capsule every 6 hours for 10 days <b>Enterocolitis Sig</b> _____		
<input type="checkbox"/> Tobi Podhaler		Inhale 4 capsules via device in the AM and PM, 28 days on, 28 days off	224	
<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 \_\_\_\_\_

I authorize Lifeline Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. **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:** \_\_\_\_\_