Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Lifeline Specialty Pharmacy

Pediatric GI/Cohn's/UC Referral Form

3233 Corporate Ct.
Ellicott City, MD 21043

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 ☐ 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:**_____

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Humira® (Citrate Free)** **Pt less than 40kg**	☐ **Humira® Starter Pack**	Inject 80mg SC day 1, then 40mg SC on day 15		
	☐ **20mg PFS**	Inject 20 mg SC every other week		
☐ **Humira® (Citrate Free)** **Pt less than 40kg**	☐ **Humira® Starter Pack**	Inject 160mg SC on day 1, then 80mg SC on day 15		
	☐ **40mg Pen** ☐ **40mg PFS**	Inject 40mg SC every other week		
☐ **Remicade**	☐ **100mg vials**	Infuse 5mg/kg at week 0, 2, and 6. Then infuse 5mg/kg every 8 weeks		
☐ **Other**_____	☐			
Topical Injection Pain Relief				
☐ **Synera**	☐ **Synera Patch** (lidocaine and tetracaine)	Apply 1 patch to injection site 20-30 minutes before administration		

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

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: _____