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

Lifeline Specialty Pharmacy — Dermatology Prescription Referral Form (I-R)

6304 Woodside Ct, Ste 100
Columbia, MD 21046

LIFELINE SPECIALTY PHARMACY

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	Sig	Qty.	Refills
☐ **Ilumya**	☐ 100 mg/ml Prefilled Syringe	☐ Induction Dose: Inject 1 pre-filled syringe SC at weeks 0 and 4, then every 12 weeks thereafter for maintenance ☐ Maintenance Dose: Inject 1 pre-filled syringe every 12 weeks		
☐ **Inflectra**	☐ 100 mg Vial	☐ Induction Dose: Infuse 5 mg/kg (Dose = ____ mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse 5 mg/kg (Dose = ____ mg) IV every 8 weeks ☐ Other: _____		
☐ **Odomzo**	☐ 200 mg Capsule	☐ Take one capsule by mouth daily on an empty stomach, 1 hour before or 2 hours after a meal		
☐ **Opzelura 1.5% Cream**	☐ 60 gram tube	☐ Apply a thin layer twice daily to affected areas of up to 20% body surface area ☐ Other: _____		
☐ **Orencia**	☐ 125 mg/mL Prefilled Syringe ☐ 125 mg/mL ClickJect Autoinjector ☐ 250 mg Vial ☐ Other	☐ Inject 125 mg SC once weekly ☐ Other: _____		
☐ **Otezla**	☐ Titration Starter Pack ☐ 30mg Tablet	☐ Use Titration Starter Pack as directed ☐ Maintenance Dose: Take one tablet (30 mg) by mouth twice daily		
☐ **Remicade** ☐ **Renflexis**	☐ 100 mg Vial	☐ Induction Dose: Infuse 5 mg/kg (Dose = ____ mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter ☐ Maintenance Dose: Infuse 5 mg/kg (Dose = ____ mg) IV every 8 weeks ☐ Other: _____		
☐ **Rinvoq**	☐ 15 mg tablet ☐ 30 mg tablet	☐ Take 1 tablet (15 mg) by mouth once daily ☐ Take 1 tablet (30 mg) by mouth once daily		
☐ **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

# of Prescriptions: _____