

Nephrology Referral Form (A-M)

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

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: _____

Office Contact Name: _____ Phone Number: _____ CoverMyMeds Email: _____

Please fax recent clinical notes, labs/rounding reports with this prescription to expedite the prior authorization process if necessary. We complete prior authorizations through CoverMyMeds. Please include the contact email for you or your prescriber's CoverMyMeds account to receive key numbers as we may need to send for the final submission. If you do not have a CoverMyMeds account please reach out to us here at the pharmacy and we will assist in creating new accounts.

3: Diagnosis/Clinical Information

Diagnosis: _____ ICD-10 Code: _____ Prior failed medications _____

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, 21043.

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Aranesp	25 mcg/ml 25 mcg/0.42 ml	Infuse _____ mcg SC once weekly Infuse _____ mcg SC _____ times a week		
	40 mcg/ml 40 mcg/0.4 ml			
	60 mcg/ml 60 mcg/0.3 ml			
	100 mcg/ml 100 mcg/0.5 ml			
	200 mcg/ml 150 mcg/0.3 ml			
	300 mcg/ml 200 mcg/0.4 ml			
	500 mcg/ml 300 mcg/0.6 ml			
Astagraf XL	0.5 mg 5 mg	Take one capsule by mouth every morning on an empty stomach Take _____ capsule(s) by mouth _____ times a day on an empty stomach		
	1 mg			
Auryxia	210 mg tablet	Take _____ tablet(s) by mouth three times a day with food Take _____ tablet(s) by mouth _____ times a day with food Other:		
CellCept	200 mg/ml 500 mg	Take _____ ml by mouth _____ times a day Take _____ tablet(s)/capsule(s) by mouth _____ times a day		
	250 mg			
Envarsus XR	0.75 mg 4 mg	Take one tablet by mouth daily at the same time everyday Take _____ tablet(s) by mouth daily _____ times a day		
	1 mg			
Epogen	2000 u/ml 20000 u/ml (1 ml vial)	Inject _____ ml SC once a week Inject _____ ml SC three times a week Inject _____ ml SC every _____ weeks		
	3000 u/ml			
	4000 u/ml 10000 u/ml (2 ml vial)			
	10000 u/ml			
Fosrenol (Lanthanum Carbonate)	500 mg 750 mg	Take _____ tablet(s) by mouth _____ times a day		
	1000 mg			
Gengraf	25 mg 100 mg	Take _____ capsule(s) by mouth twice a day Take _____ capsules(s) by mouth _____ times a day		
	50 mg			
Myfortic	180 mg 360 mg	Take _____ tablets(s) by mouth twice a day on an empty stomach Take _____ tablets(s) by mouth _____ times a day on an empty stomach		

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

of Prescriptions: _____