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 (A-H)

6304 Woodside Ct, Ste 100
Columbia, MD 21046

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
☐ Amjevita	☐ 40mg Sureclick Pen ☐ 40mg PFS ☐ 20mg PFS	☐ Inject 40mg SC ☐ once a week or ☐ every other week ☐ Inject 80mg SC on Day 1, then 40mg SC every other week starting Day 8 ☐ Inject 80mg SC every other week		
☐ Avsola	☐ 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		
☐ Cibinqo	☐ 50 mg tablet ☐ 200 mg tablet ☐ 100 mg tablet	☐ Take 1 tablet by mouth once a day		
☐ Cimzia	☐ Cimzia Starter Kit ☐ 200 mg x2 Prefilled Syringes ☐ 200 mg x2 Single dose Vials	☐ Induction Dose: Inject 400mg SC on Day 0, at week 2, & week 4 ☐ Inject ☐ 200 mg or ☐ 400 mg ☐ every other week ☐ every 2 weeks ☐ Maintenance Dose: Inject 400mg SC once every 4 weeks		
☐ Cosentyx	☐ 150mg Sensoready Pen ☐ 150mg PFS	☐ Induction Dose: Inject ☐ 150mg or ☐ 300mg SC weekly for 5 weeks ☐ Maintenance Dose: Inject ☐ 150 or ☐ 300mg SC every 4 weeks		
☐ Dupixent	☐ 200 mg PFS ☐ 300 mg PFS ☐ 200 mg Pen ☐ 300 mg Pen	☐ Induction/Maintenance: Inject ☐ 200 mg or ☐ 300 mg SC every 4 weeks ☐ Induction Dose: Inject 400 mg SC on day 1, then 200 mg on day 15 ☐ Induction Dose: Inject 600 mg SC on day 1, then 300 mg on day 15 ☐ Maintenance Dose: Inject ☐ 200 mg or ☐ 300 mg SC ☐ every other week or ☐ every 4 weeks		
☐ Enbrel	☐ 50mg Sureclick ☐ 50mg Syringe ☐ 50mg Mini ☐ 25mg PFS ☐ 25mg/ml Vials	☐ Inject 50mg SC once a week ☐ Inject ____mg SC_____a week		
☐ Humira ☐ Humira (Citrate Free)	☐ 40mg Pen ☐ 40mg Prefilled Syringe ☐ HS Starter Pkg ☐ Psoriasis Starter Pkg	☐ Induction Dose: Inject 80 mg SC on day 1, then 40 mg on day 8, then 40 mg every other week ☐ Induction Dose: Inject 160 mg SC on day 1, then 80 mg on day 15, then 40 mg every week ☐ Induction Dose: Inject 80 mg SC on day 1, and day 2, then 80 mg on day 15, then 40 mg every week ☐ Maintenance Dose: Inject 40 mg SC ☐ every week ☐ every 2 weeks		
☐ 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

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: __________