

Lifeline Specialty Pharmacy

Crohn's/GI/UC Prescription Referral Form (S-Z)

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 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: _____

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.

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100 mg Smartject <input type="checkbox"/> 100 mg Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 200 mg SC at weeks 0, then inject 100 mg SC at week 2 <input type="checkbox"/> Maintenance Dose: Inject 100 mg SC every 4 weeks		
<input type="checkbox"/> Skyrizi®	<input type="checkbox"/> 600 mg Vial <input type="checkbox"/> 180 mg/1.2 mL OBI <input type="checkbox"/> 360/2.4 mL OBI	<input type="checkbox"/> Induction Dose: Infuse 600 mg via IV at week 0, week 4, and week 8 <input type="checkbox"/> Inject 180 mg SC at week 12 and every 8 weeks thereafter <input type="checkbox"/> Inject 360 mg SC at week 12 and every 8 weeks thereafter <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Stelara Starter Dose®	<input type="checkbox"/> 2 x 130 mg/26 mL <input type="checkbox"/> 3 x 130 mg/26 mL <input type="checkbox"/> 4 x 130 mg/26 mL	<= 55kg <input type="checkbox"/> Infuse 260mg IV as induction dose over at least 1 hour > 55kg to <= 85kg <input type="checkbox"/> Infuse 390 mg IV as induction dose over at least 1 hour > 85 kg <input type="checkbox"/> Infuse 520mg IV as induction dose over at least 1 hour <input type="checkbox"/> Low-dose induction: Infuse 130 mg IV over at least 1 hour		
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 1 x 90 mg/ml PFS	<input type="checkbox"/> Inject 90 mg SC 8 weeks after initial IV dose and then every 8 weeks thereafter		
<input type="checkbox"/> Tysabri®	<input type="checkbox"/> 300 mg/15 mL	<input type="checkbox"/> Infuse 300 mg IV over 1 hour every 4 weeks		
<input type="checkbox"/> Xeljanz/XR®	<input type="checkbox"/> 5 mg Tablet <input type="checkbox"/> 10 mg Tablet <input type="checkbox"/> 11 mg Tablet <input type="checkbox"/> 22 mg Tablet	Induction Doses: <input type="checkbox"/> Take 10mg by mouth twice daily for ____ weeks <input type="checkbox"/> Take 22mg by mouth once daily for ____ weeks Maintenance Doses: <input type="checkbox"/> Take 5 mg by mouth twice daily <input type="checkbox"/> Take 11 mg by mouth once daily		
<input type="checkbox"/> Zeposia®	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 0.92 mg Capsule	<input type="checkbox"/> Titration: Take 0.23 mg by mouth on week 0 and advance as directed <input type="checkbox"/> Maintenance Dose: Take 0.92 mg by mouth once daily		
<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 _____

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: _____