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

Crohn's/GI/UC Prescription Referral Form (A-R)

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
☐ **Cimzia®**	☐ Prefilled Syringes (2x200mg) ☐ Lyophilized Vials (2x200 mg)	☐ **Induction Dose**: Inject 400 mg subcutaneously at weeks 0, 2 and ☐ **Maintenance Dose**: Inject 400 mg subcutaneously every 4 weeks		
☐ **Dupixent®**	☐ 200 mg/1.14mL pen ☐ 200 mg/1.14mL PFS ☐ 300 mg/2mL pen ☐ 300 mg/2mL PFS	☐ 15 kg to <30 kg: Inject 200 mg subcutaneously every other week ☐ 30 kg to <40 kg: Inject 300 mg subcutaneously every other week ☐ > 40 mg: Inject 300 mg subcutaneously once a week		
☐ **Humira®** ☐ **Humira® Citrate Free (CF)**	☐ 20mg Pen ☐ 20mg PFS ☐ 40mg PFS ☐ 40mg Pen ☐ 80 mg Pen	**Induction Doses:** ☐ Inject 160 mg subcutaneously on Day 1, then inject 80 mg SC on day 15 ☐ Inject 80 mg SC on Day 1, then inject 80 mg SC on day 2, then inject 80 mg SC on day 15 **Maintenance Doses:** ☐ Inject 40 mg SC every other week ☐ Inject 80 mg SC every other week ☐ Other: _______________		
☐ **Remicade®**	☐ 100mg vial Patients Weight: ______	☐ **Induction Dose**: Infuse _____ mg/kg via IV at week 0, week 2, and week 6 ☐ **Maintenance Dose**: Infuse _____ mg/kg via IV every 8 weeks ☐ Other: _______________		
☐ **Rinvoq®**	☐ 45 mg Tablet	☐ Take 45 mg by mouth once daily for 8 weeks		
	☐ 15 mg Tablet ☐ 30 mg mg Tablet	☐ Take 30 mg by mouth once daily ☐ Take 15 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

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: ___________