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.

Rheumatoid Arthritis Prescription Referral Form A-N

3233 Corporate Ct.
Ellicott City, MD 21042

LIFELINE SPECIALTY PHARMACY

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 ☐ 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:**

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information | Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

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**_____ **Is patient currently on RA therapy? 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	Formulation	Sig	Qty.	Refills
☐ **Actemra**	☐ 162mg	☐ Pen ☐ Prefilled Syringe	☐ Inject 162mg SC ☐ once a week or ☐ every other week		
	☐ _____ Vial		☐ Inject _____ mg every 4 weeks		
☐ **Amjevita**	☐ 10mg/0.2ml ☐ 20mg/0.4ml	☐ PFS	☐ Inject ____mg SC every other week ☐ Inject ____mg on Day 1, ____mg on Day 15, then ____mg every ____ week		
	☐ 40mg/0.8ml	☐ PFS ☐ Sureclick Pen	☐ Inject 80mg SC once, then 40mg every other week starting Day 8		
☐ **Cimzia**	☐ 200mg	☐ Starter Kit	☐ Induction Dose: Inject 400mg SC on Day 0, at week 2, & week		
		☐ SDV ☐ Prefilled Syringe	☐ Inject _____mg SC once every _____ weeks		
☐ **Cosentyx**	☐ 150mg	☐ PFS ☐ Sensoready Pen	☐ Inject _____mg SC every _____ weeks		
☐ **Cyltezo**	☐ 10mg/0.2ml ☐ 20mg/0.4ml	☐ PFS	☐ Inject ____mg SC every other week ☐ Inject ____mg on Day 1, ____mg on Day 15, then ____mg every ____ week		
	☐ 40mg/0.8ml	☐ PFS ☐ Pen	☐ Inject 80mg SC once, then 40mg every other week starting Day 8		
☐ **Enbrel**	☐ 25mg ☐ 50mg	☐ PFS ☐ Vials ☐ Sureclick ☐ Syringe ☐ Mini	☐ Inject ____mg SC _____a week ☐ (72-96 hours apart)		
☐ **Hadlima**	☐ 40mg/0.4ml ☐ 40mg/0.8ml	☐ Autoinjector ☐ Prefilled Syringe	☐ Inject ____mg SC every other week ☐ Inject 80mg SC once, then 40mg every other week starting Day 8		
☐ **Hulio**	☐ 20mg	☐ Prefilled Syringe	☐ Inject 160mg on day 1, 80mg on day 15, then ___mg every ___week		
	☐ 40mg	☐ Pen ☐ Prefilled Syringe			
☐ **Humira** ☐ **CF**	☐ 40mg	☐ Pen ☐ Prefilled Syringe	☐ Inject 40mg SC every _____ week		
☐ **Hyrimoz**	☐ 10mg ☐ 40mg ☐ 20mg ☐ 80mg	☐ PFS ☐ Pen	☐ Inject ____mg SC every other week ☐ Inject 80mg SC once, then 40mg every other week starting Day 8		
	☐ 80+40mg	☐ Starter Kit	☐ Inject 160mg on day 1, 80mg on day 15, then ___mg every ___week		
☐ **Idacio**	☐ 40mg/0.8ml	☐ PFS ☐ Pen			
☐ **Inflectra**	☐ 100mg	☐ Vials	☐ Infuse _____mg at week 0, 2, 6, and then every 8 weeks thereafter ☐ Infuse _____mg SC every_____weeks		
☐ **Kevzara**	☐ 150mg ☐ 200mg	☐ Pen ☐ PFS	☐ Inject 1 pen or syringe SC every 2 weeks		

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: _____