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 O-Z

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

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 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 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 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
☐ **Olumiant**	☐ 2mg	☐ Take 1 tablet by mouth daily		
☐ **Orencia**	☐ 125mg PFS ☐ 125 mg ClickJet	☐ Inject 125 mg SC once a week		
	☐ 250mg Vials	☐ Infuse___mg at_____		
☐ **Otezla**	☐ Titration Starter Pack	☐ Use Titration Starter Pack as directed		
	☐ 30mg Tablet	☐ Maintenance Dose: Take one 30mg tablet orally twice daily		
☐ **Otrexup**	☐ 12.5mg ☐ 17.5mg ☐ 22.5mg ☐ 15mg ☐ 20mg ☐ 25mg	☐ Inject _____ mg SQ weekly		
☐ **Pen Needles**	☐ 31 gauge 6mm			
☐ **Rasuvo**	☐ 7.5mg/0.15ml ☐ 15mg/0.3ml ☐ 22.5mg/0.4ml ☐ 10mg/0.2ml ☐ 17.5mg/0.35ml ☐ 25mg/0.5ml ☐ 12.5mg/0.25ml ☐ 20mg/0.4ml ☐ 30mg/0.6ml	☐ Inject _____ mg SQ weekly		
☐ **Remicade**	☐ 100 mg Vials	☐ Infuse _____ mg at week 0, 2, 6, and then every 8 weeks thereafter ☐ Infuse _____ mg SQ every _____ weeks		
☐ **Rinvoq**	☐ 15 mg tablet	☐ Take one tablet by mouth daily		
☐ **Rituxan**	☐ 100mg/10ml ☐ 500mg/50ml	☐ Infuse ____mg IV every ___ weeks, repeat ____mg every ____months ☐ Other: _____		
☐ **Simponi**	☐ 50 mg SmartJet ☐ 50 mg PFS ☐ Aria ☐ 100 mg SmartJet ☐ 100 mg PFS	☐ Infuse ____ mg once a month as directed ☐ Infuse ____ mg at weeks 0, 2, and 6 and every 8 weeks thereafter		
☐ **Stelara**	☐ 45mg PFS ☐ 90mg PFS	☐ Inject 45 mg on day 0, then 4 weeks, then every 12 weeks (<100 kg) ☐ Inject 90 mg on day 0, then 4 weeks, then every 12 weeks (>100 kg) ☐ Inject _____ mg SC every _____ weeks		
☐ **Taltz**	☐ 80mg Auto ☐ 80mg PFS	☐ Psoriatic Arthritis: Inject 160mg on day 1, then 80mg every 4 weeks ☐ Plaque Psoriasis: Inject 160mg on day 1, then 80mg every 2 weeks ☐ Maintenance Dose: Inject 80mg every 4 weeks		
☐ **Tremfya**	☐ 100 mg PFS ☐ 100 mg Auto	☐ Starting Dose: Inject 100 mg SC at weeks 0 and 4 ☐ Maintenance Dose: Inject 100 mg SC every 8 weeks		
☐ **Xeljanz**	☐ 5mg Tablets ☐ 10mg Tablets	☐ Take 1 tablet by mouth twice daily		
☐ **Xeljanz XR**	☐ 11mg Tablets	☐ Take 1 tablet by mouth daily		

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:_____