

Auryxia/ Renvela/ Fosrenol Referral Form

3233 Corporate Ct.
Ellicott City, MD 21042



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

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

Diagnosis and ICD-10 Code:

E83.39: Hyperphosphatemia

D63.1: Iron Deficiency Anemia in CKD

D50.9: Iron Deficiency Anemia

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

Medication/Dose/Strength	Directions	Qty.	Refills
Auryxia (Ferric Citrate) 210 mg tablet	Take ____ tablet(s) by mouth three times per day with food	30 day supply	
Renvela (Sevelamer) 800 mg tablet			
Renvela (Sevelamer) 0.8 g packet	Take ____ tablet(s) by mouth ____ time(s) per day with food	90 day supply	
Renvela (Sevelamer) 2.4 g packet			
Fosrenol (Lanthanum Carbonate) 500 mg tablet	Dissolve 1 packet (s) in minimum 2 oz of water and drink three times per day with food		
Fosrenol (Lanthanum Carbonate) 750 mg tablet	Dissolve ____ packet (s) in minimum 2 oz of water and drink ____ times per day with food		
Fosrenol (Lanthanum Carbonate) 1000 mg tablet	Other: _____		

Office Contact Name: _____ Phone Number: _____

CoverMyMeds Email: _____

Please fax recent clinical notes, labs/rounding reports with this prescription to expedite the prior authorization process if necessary. We complete prior authorizations through CoverMyMeds. Please include the contact email for you or your prescriber's CoverMyMeds account to receive key numbers as we may need to send for the final submission. If you do not have a CoverMyMeds account please reach out to us here at the pharmacy and we will assist in creating new accounts.

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: _____