



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

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 \_\_\_\_\_ Location: Hands Feet Knees Spine Other: \_\_\_\_\_ Latex allergy? 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, 21043.

## 4: Prescription Information | Xeljanz NOT to be used in combination with biologic DMARD's

Medication	Dose/Strength	Sig	Qty.	Refills
<input type="checkbox"/> Silliq	<input type="checkbox"/> 210 mg PFS	<input type="checkbox"/> Induction Dose: Inject 210 mg SC on weeks 0, 1 and 2, then every 2 weeks <input type="checkbox"/> Maintenance Dose: Inject 210 mg SC once every 2 weeks		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50 mg Smartject <input type="checkbox"/> 100 mg Smartject <input type="checkbox"/> 50 mg PFS <input type="checkbox"/> 100 mg PFS <input type="checkbox"/> Aria 50 mg/4 ml	<input type="checkbox"/> Inject ___ mg once a month as directed <input type="checkbox"/> Inject ___ mg at week 0, 2, 6, and then every 8 weeks		
<input type="checkbox"/> Skyrizi	<input type="checkbox"/> 150 mg Pen <input type="checkbox"/> 150 mg PFS	<input type="checkbox"/> Induction Dose: Inject 150mg SC on week 0 and week 4 <input type="checkbox"/> Maintenance Dose: Inject 150 mg every 12 weeks		
<input type="checkbox"/> Sotyktu	<input type="checkbox"/> 6 mg tablets	<input type="checkbox"/> Take 1 tablet by mouth daily		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45 mg PFS <input type="checkbox"/> 90 mg PFS	<input type="checkbox"/> Induction Dose: Inject 45 mg on day 0, then week 4, then every 12 weeks <input type="checkbox"/> Induction Dose: Inject 90 mg on day 0, then week 4, then every 12 weeks <input type="checkbox"/> Maintenance Dose: Inject ___ mg SC every ___ weeks		
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80 mg Autoinjector <input type="checkbox"/> 80 mg Prefilled Syringe	<input type="checkbox"/> Psoriatic Arthritis: Inject 160 mg on day 1, then 80 mg every 4 weeks <input type="checkbox"/> Plaque Psoriasis: Inject 160 mg on day 1, then 80 mg every 2 weeks <input type="checkbox"/> Maintenance Dose: Inject 80 mg SC every 4 weeks		
<input type="checkbox"/> Tremfya	<input type="checkbox"/> 100 mg Injector <input type="checkbox"/> 100 mg Prefilled Syringe	<input type="checkbox"/> Induction Dose: Inject 100 mg SC on week 0 and week 4 <input type="checkbox"/> Maintenance Dose: Inject 100 mg SC every 8 weeks		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5 mg tablets <input type="checkbox"/> 10 mg tablets <input type="checkbox"/> XR 11 mg tablets	<input type="checkbox"/> Take 1 tablet by mouth twice daily <input type="checkbox"/> Take 1 tablet by mouth daily		
<input type="checkbox"/> Vtama 1% Cream	<input type="checkbox"/> 60 Gram Tube	<input type="checkbox"/> Apply a thin layer topically to affected areas once daily		
<input type="checkbox"/> Zoryve 0.3% Cream	<input type="checkbox"/> 60 Gram Tube	<input type="checkbox"/> Apply topically to affected areas 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/JOH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: \_\_\_\_\_