

Lifeline Specialty Pharmacy

# Crohn's / GI / UC Prescription Referral Form

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)	<b>Starter Dose:</b> Inject 400mg SC at weeks 0, 2, and 4		0
	Lyophilized vials (2 x 200mg)	<b>Maintenance Dose:</b> 400mg SC every 4 weeks		
Humira®	20mg Pen	<b>Starter Dose:</b> Inject 160mg SC for first Dose (Day 1). Then Inject 80mg SC two weeks after first dose (Day 15). Then inject 40mg SC every OTHER week starting at week 4 (Day 29) <b>Maintenance Dose:</b> Inject 40mg SC (one 40mg Pen) every other week Other: _____		0
	20mg PFS			
Humira® Citrate Free (CF)	40mg Pen			
	40mg PFS Starter Pack			
Xifaxan®	200mg tabs    550mg tabs	Take _____ tablets _____ times per day		
Remicade®	100mg vial	Infuse 100 mg IV at at 0, 2 and 6 weeks, and then every 8 weeks thereafter Other: _____		
Simponi®	100mg SmartJect® 100mg Prefilled Syringe	<b>Starter Dose:</b> Inject 200mg SC at week 0, then 100mg SC at week 2, then start maintenance at week 6 <b>Maintenance Dose:</b> 100mg SC every 4 weeks starting at week 6, after Induction dose	3	0
			1	
Entyvio®	300mg vial	Infuse 300 mg IV at 0, 2, and 6 weeks and every 8 weeks thereafter		
Dificid®	200mg tabs	Take 1 tablet twice daily with or without food for 10 days	20 Tablets	
Stelara® Starter Dose	2x 130mg/26ml 3x 130mg/26ml 4x 130mg/26ml	<=55kg Infuse 260mg IV as induction dose over at least 1 hour >55kg to <=85kg Infuse 390mg IV as induction dose over at least 1 hour >85kg Infuse 520mg IV as induction dose over at least 1 hour Low-dose induction: Infuse 130mg IV over at least 1 hour	vials	0
Stelara®	1x 90mg/ml Prefilled Syringe	Inject 90mg SC 8 weeks after initial IV dose and then every 8 weeks thereafter	1x90mg/ml PFS	
Tysabri®	300mg/15 ml	Infuse 300 mg IV over 1 hour every 4 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 \_\_\_\_\_

**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 VAJOH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

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