

# Dermatology Prescription Referral Form (A-O)

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 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, 21042.

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

Medication	Dose/Strength	Sig	Qty.	Refills
<input type="checkbox"/> Amjevita	<input type="checkbox"/> 40mg Sureclick Pen <input type="checkbox"/> 40mg PFS <input type="checkbox"/> 20mg PFS	<input type="checkbox"/> Inject 40mg SC <input type="checkbox"/> once a week or <input type="checkbox"/> every other week <input type="checkbox"/> Inject 80mg SC on Day 1, then 40mg SC every other week starting Day 8 <input type="checkbox"/> Inject 80mg SC every other week		
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Cimzia Starter Kit <input type="checkbox"/> 200 mg x2 Prefilled Syringes <input type="checkbox"/> 200 mg x2 Single dose Vials	<input type="checkbox"/> Induction Dose: Inject 400mg SC on Day 0, at week 2, & week 4 <input type="checkbox"/> Inject <input type="checkbox"/> 200 mg or <input type="checkbox"/> 400 mg <input type="checkbox"/> every other week <input type="checkbox"/> every 2 weeks <input type="checkbox"/> Maintenance Dose: Inject 400mg SC once every 4 weeks		
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg Sensoready Pen <input type="checkbox"/> 150mg PFS	<input type="checkbox"/> Induction Dose: Inject <input type="checkbox"/> 150mg or <input type="checkbox"/> 300mg SC weekly for 5 weeks <input type="checkbox"/> Maintenance Dose: Inject <input type="checkbox"/> 150 or <input type="checkbox"/> 300mg SC every 4 weeks		
<input type="checkbox"/> Dupixent	<input type="checkbox"/> 200 mg PFS <input type="checkbox"/> 300 mg PFS <input type="checkbox"/> 200 mg Pen <input type="checkbox"/> 300 mg Pen	<input type="checkbox"/> Induction/Maintenance: Inject <input type="checkbox"/> 200 mg or <input type="checkbox"/> 300 mg SC every 4 weeks <input type="checkbox"/> Induction Dose: Inject 400 mg SC on day 1, then 200 mg on day 15 <input type="checkbox"/> Induction Dose: Inject 600 mg SC on day 1, then 300 mg on day 15 <input type="checkbox"/> Maintenance Dose: Inject <input type="checkbox"/> 200 mg or <input type="checkbox"/> 300 mg SC <input type="checkbox"/> every other week or <input type="checkbox"/> every 4 weeks		
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 50mg Sureclick <input type="checkbox"/> 50mg Syringe <input type="checkbox"/> 50mg Mini <input type="checkbox"/> 25mg PFS <input type="checkbox"/> 25mg/ml Vials	<input type="checkbox"/> Inject 50mg SC once a week <input type="checkbox"/> Inject _____mg SC _____a week		
<input type="checkbox"/> Humira (Citrate Free)	<input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Prefilled Syringe <input type="checkbox"/> HS Starter Pkg <input type="checkbox"/> Psoriasis Starter Pkg	<input type="checkbox"/> Induction Dose: Inject 80 mg SC on day 1, then 40 mg on day 8, then 40 mg every other week <input type="checkbox"/> Induction Dose: Inject 160 mg SC on day 1, then 80 mg on day 15, then 40 mg every week <input type="checkbox"/> Induction Dose: Inject 80 mg SC on day 1, and day 2, then 80 mg on day 15, then 40 mg every week <input type="checkbox"/> Maintenance Dose: Inject 40 mg SC <input type="checkbox"/> every week <input type="checkbox"/> every 2 weeks		
<input type="checkbox"/> Odomzo	200 mg Capsule	Take one capsule by mouth daily on an empty stomach, 1 hour before or 2 hours after a meal		
<input type="checkbox"/> Otezla	<input type="checkbox"/> Titration Starter Pack <input type="checkbox"/> 30mg Tablet	<input type="checkbox"/> Use Titration Starter Pack as directed <input type="checkbox"/> Maintenance Dose: Take one 30 mg tablet orally twice 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/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

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