

# Rheumatoid Arthritis Prescription Referral Form O-Z

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  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
<input type="checkbox"/> Olumiant	2mg			<input type="checkbox"/> 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	Inject _____ mg SQ weekly		
	15mg	20mg	25mg			
Pen Needles	31 gauge 6mm					
Rasuvo	7.5mg/0.15ml	15mg/0.3ml	22.5mg/0.4ml	Inject _____ mg SQ weekly		
	10mg/0.2ml	17.5mg/0.35ml	25mg/0.5ml			
	12.5mg/0.25ml	20mg/0.4ml	30mg/0.6ml			
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	Infuse _____ mg once a month as directed		
	100 mg SmartJet	100 mg PFS		Infuse _____ mg at weeks 0, 2, and 6 and every 8 weeks thereafter		
Stelara	45mg PFS			Inject 45 mg on day 0, then 4 weeks, then every 12 weeks (<100 kg)		
	90mg PFS			Inject 90 mg on day 0, then 4 weeks, then every 12 weeks (>100 kg)		
				Inject _____ mg SC every _____ weeks		
Taltz	80mg Auto			Psoriatic Arthritis: Inject 160mg on day 1, then 80mg every 4 weeks		
	80mg PFS			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: \_\_\_\_\_