Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

Lucemyra Referral Form

3233 Corporate Ct.
Ellicott City, MD 21042

LIFELINE SPECIALTY PHARMACY

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

☐ **F11.23 Opioid Dependence w/withdrawal** ☐ **F11.13 Opioid Abuse w/ withdrawal** ☐ **Other:** _____

☐ **Prior failed medications (medication and duration of treatment/reason for d/c):** _____

4. Prescription Information

Medication/Dose/Strength	Directions	Qty	Refills
☐ **Lucemyra 0.18 tablets**	☐ **Take 3 tablets by mouth 4 times daily on days 1-7, 2 tablets by mouth 4 times daily on day 8, 1 tablet by mouth 4 times daily on day 9 then discontinue**	☐ **96 tablets**	
	☐ **Take 1-4 tablets by mouth 4 times daily, as guided by symptoms, not to exceed 16 tablets per day**	☐ **192 tablets**	
	☐ **Take 3 tablets by mouth 4 times daily with 5-6 hours between each dose for first 5-7 days following last opioid use and remaining days dosing to be guided by symptoms and side effects as directed**	☐ **Other:** _____ **tablets**	
	☐ **Other:** _____		

5. Patient Support and Injection Training Authorization

I authorize Lifeline Specialty Pharmacy to enroll the patient in the pharmaceutical manufacturer support program that pertains to prescribed therapy. The purpose of this enrollment is to assist the patient in receiving services, like injection training and administration of 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.

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 the 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: Please sign, date and select an option below

Signature _____ Date: _____ ☐ Substitution Permissible ☐ Dispense as written

# of Rx: _____