Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Lifeline Specialty Pharmacy

Infectious Disease Referral Form

6304 Woodside Ct, Ste 100
Columbia, MD 21046

LIFELINE SPECIALTY PHARMACY

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:**_____

Drug Allergies:_____ **Previous/Failed Medications**_____ **Date and Duration of Therapy**_____

5: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Cresemba**	☐ **186mg tablet**	☐ Take____ tablets by mouth____ time(s) a day ☐ Other_____		
☐ **Dificid**	☐ **200mg tablet**	Take one tablet by mouth twice a day		
☐ **Noxafil**	☐ **100mg tablet**	☐ Take____ tablets by mouth____ time(s) a day ☐ Other_____		
☐ **Santyl**	☐ _____	Wound 1:____x____cm Location_____ Apply to wound once daily (or more frequently if dressing becomes soiled) for ____ days Wound 2:____x____cm Location_____ Wound 3:____x____cm Location_____		
☐ **Vancomycin**	☐ **125mg capsule** ☐ **250mg capsule**	**Clostridium Dificile:** Take a 125mg capsule every 6 hours for 10 days **Enterocolitis Sig**_____		
☐ **Tobi Podhaler**		Inhale 4 capsules via device in the AM and PM, 28 days on, 28 days off	**224**	
☐ **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

I authorize Lifeline Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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: _____