



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 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"/> Avsola	<input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> Induction Dose: Infuse 5 mg/kg (Dose = ____ mg) IV at week 0, week 2, week 6 and every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: Infuse 5 mg/kg (Dose = ____ mg) IV every 8 weeks		
<input type="checkbox"/> Cibinqo	<input type="checkbox"/> 50 mg tablet <input type="checkbox"/> 200 mg tablet <input type="checkbox"/> 100 mg tablet	<input type="checkbox"/> Take 1 tablet by mouth once a day		
<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"/> Ebglyss	<input type="checkbox"/> 250 mg Pen <input type="checkbox"/> 250mg PFS	<input type="checkbox"/> Induction Dose: Inject 500 mg at Week 0 and Week 2 <input type="checkbox"/> Induction Dose: Inject 250 mg every 2 weeks until Week 16 <input type="checkbox"/> Maintenance Dose: Inject 250 mg 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"/> 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/JOH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____